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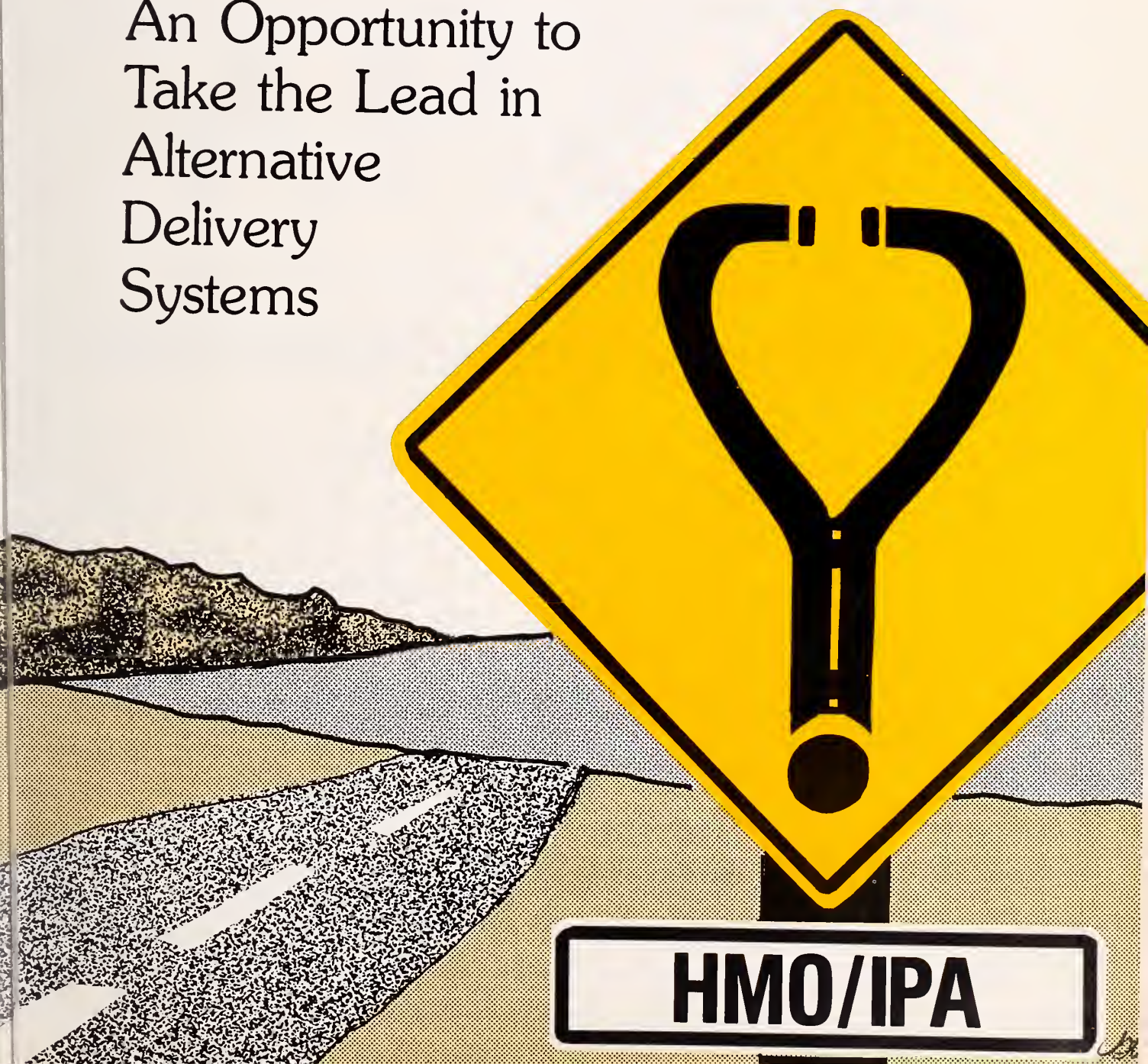
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JANUARY 1986

JOURNAL of the MISSISSIPPI State Medical Association

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JOURNAL of the MISSISSIPPI State Medical Association

JANUARY 1986, VOLUME XXVII, NUMBER 1

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The Journal of the Mississippi State Medical Association is owned and published monthly by the Mississippi State Medical Association, founded 1856. at 735 Riverside Drive, Jackson, Mississippi 39202. Subscription rate, $25.00 per annum; $35.00 per annum for foreign subscriptions; $2.25 per copy, as available. Advertising rates furnished on request. Printed by The Ovid Bell Press, Inc., Fulton, Missouri. Second-class postage paid at Jackson, Mississippi, and at additional mailing offices. POSTMASTER: Send address changes to Mississippi State Medical Association, 735 Riverside Drive, Jackson, Mississippi 39202.

CONTENTS

ORIGINAL PAPERS

Ruptured Thoracic Aortic Aneurysm with Aorto-Esophageal Fistula — **1** Martin Dalton, M.D., Barry Newsom, M.D., Steven A. Isbell, M.D., and J. Harold Conn, M.D.

Experience with Methacholine Inhalation Challenge in the Evaluation of Chest Symptoms — **5** Victor E. Salter, M.D.

Acromegaly: A Case Report — **9** Willie L. Wells, M.D.

EDITORIAL

MSMA Physicians at a Crossroads: Will We Lead or Follow? — **13** Myron W. Lockey, M.D.

THIS MONTH

Hippocrates Revisited — **12** The President Speaking
13 Medico-Legal Brief
15 Medical Organization
18 Personals
23 New Members

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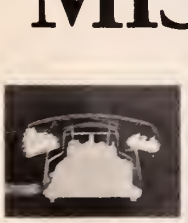
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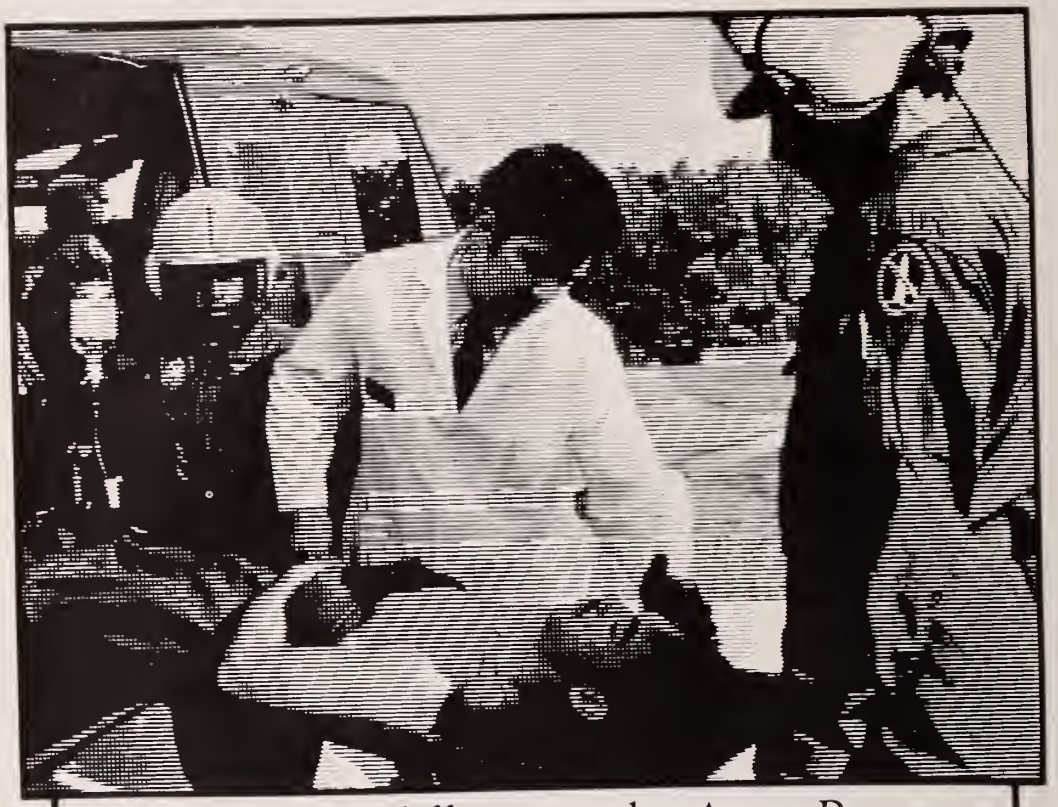
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NEWSLETTER

January 1986

Dear Doctor:

"Physicians are at a crossroads." Those are words from an editorial in this issue which encourages MSMA member support of and participation in the association's HMO/IPA. The alternative delivery plan was described in a mailing last month to MSMA members. The prospectus also offered shares of preferred stock in the Mississippi Physicians Health Insurance Company and outlined formation of the Mississippi Physicians Practice Association.

"This exciting and ambitious enterprise," in the words of MSMA president Ralph L. Brock, M.D., "will assure that high-quality medicine is preserved," along with the benefit of cost savings that the HMO is expected to achieve through utilization and quality of care management. In his letter accompanying the prospectus, Dr. Brock emphasized that one of the goals of the MSMA project is to have a large, open panel of physicians which will maximize patients' freedom of choice.

Physicians familiar with the 18-month-long study that led to the development of the statewide HMO/IPA consider the project a positive step in view of the dramatic changes facing the profession.

The need for a positive attitude was the theme of AMA president Harrison L. Rogers, M.D., when he addressed the AMA Interim Meeting last month in Washington, D.C. Physicians' negative attitudes about the future of the profession are "more dangerous...than anything that is being imposed or anything that can be imposed on us in the future from outside," he told delegates. Dr. Rogers emphasized that the dramatic changes facing medicine "will not in the slightest affect the quality of care given by us to our individual patients -- if we truly remain our patients' advocate; if we remain their compassionate, concerned, dedicated physicians."

Sincerely,

Patsy Silver

Patsy Silver
Managing Editor



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DATELINE

HMO Enrollments Set Record Increase

Excelsior, MN - Enrollments in health maintenance organizations (HMO) increased by a record 25% in the period June 1984 - June 1985, surpassing the previous record increase of 21.1% set in 1984. The figures were reported by InterStudy, a health policy research organization, which also noted that the number of HMOs has increased to 29%, bringing the total of HMOs across the country to 393.

Reye Syndrome Cases Decreasing

Chicago, IL - A new study which traced the use of medications given to young children with febrile or viral illnesses in Michigan has found a decrease in the incidence of Reye Syndrome - perhaps a result of decreased aspirin use among children. The report also cited a national decrease in cases in children under 10, but a constant rate in those over 10, suggesting that older children may be self-medicating.

Most Ob-Gyns Face Claims

Washington, DC - An American College of Obstetricians and Gynecologists study shows that nearly three-quarters of ob-gyns reported they had malpractice claims filed against them in 1985, compared with two-thirds in 1983. And nearly half of ob-gyns had two or more claims filed against them. The report notes a significant change in practice patterns, including limiting of practices and increasing tests and diagnostic procedures.

NIH Guidelines for Breast Cancer Treatment

Chicago, IL - Adjuvant chemotherapy has demonstrated a significant increase in disease-free survival as well as a significant reduction in mortality in premenopausal women with breast cancer, according to a National Institutes of Health consensus conference report published in the December 26 issue of JAMA. Usefulness of adjuvant chemotherapy for postmenopausal women is less well established, the report adds.

Scientific Exhibit Space Available

Jackson, MS - Applications are now being accepted from MSMA members for scientific exhibit space at MSMA's 1986 Annual Session. The meeting will be held June 4-8 at the Royal d'Iberville Hotel in Biloxi. Applicants should write a letter requesting space, furnishing the title, name of sponsor(s) and the amount of linear feet required for the proposed exhibit. Space is limited, so early application is encouraged.

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- ALDOSE REDUCTASE INHIBITION
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PARTIAL LIST OF GUEST SPEAKERS

DAVID J. APPLE, M.D.
University of Utah School of Medicine

MANUEL B. DATILES, M.D.
National Eye Institute

ROBERT M. SINSKEY, M.D.
Santa Monica, California

LEO T. CHYLACK, JR., M.D.
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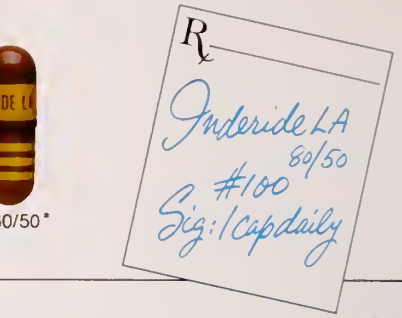
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CONTRAINDICATIONS

Propranolol hydrochloride (INDERAL®):
Propranolol is contraindicated in: 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol.

Hydrochlorothiazide:
Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS

Propranolol hydrochloride (INDERAL®):
CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, it necessary they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely; or propranolol should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of propranolol therapy. Therefore, when discontinuance of propranolol is planned, the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patients should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy, and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide:
Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS

Propranolol hydrochloride (INDERAL®):
GENERAL. Propranolol should be used with caution in patients with impaired hepatic or renal function. Propranolol is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that propranolol may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs, such as reserpine, should be closely observed if propranolol is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY. Pregnancy Category C. Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose. There are no adequate and well-controlled studies in pregnant women. Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS. Propranolol is excreted in human milk. Caution should be exercised when propranolol is administered to a nursing mother.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

Hydrochlorothiazide:
GENERAL. Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance: namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are: Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect of digitalis (eg, increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content.

Any chloride deficit is generally mild and usually does not require specific treatment, except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism, such as renal lithiasis, bone resorption, and peptic ulceration have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

DRUG INTERACTIONS: Thiazide drugs may increase the responsiveness to tubocurarine. The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

PREGNANCY. Pregnancy Category C. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnancy requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

NURSING MOTHERS. Thiazides appear in human milk. If use of the drug is deemed essential, the patient should stop nursing.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL®):
Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

Hydrochlorothiazide:
Gastrointestinal: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis.

Central Nervous System: Dizziness, vertigo, paresthesias, headache, xanthopsia.

Hematologic: Leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

Cardiovascular: Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity: Purpura, photosensitivity, rash, urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis); fever, respiratory distress, including pneumonitis, anaphylactic reactions.

Other: Hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

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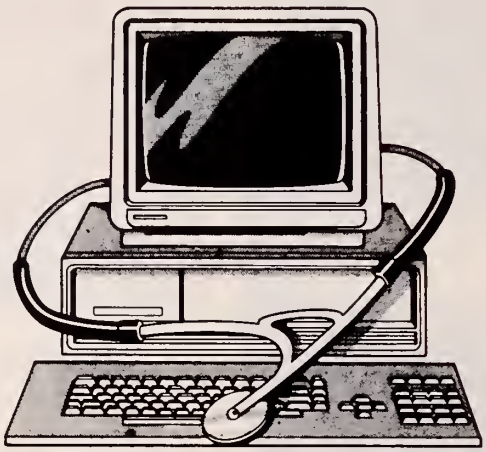
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January 1986, Volume XXVII, Number 1

ORIGINAL PAPERS

Ruptured Thoracic Aortic Aneurysm With Aorto-Esophageal Fistula

MARTIN DALTON, M.D., BARRY NEWSOM, M.D., STEVEN A. ISBELL, M.D., and J. HAROLD CONN, M.D.
Jackson, Mississippi

The morbidity and mortality of descending thoracic aortic aneurysms have been greatly underestimated. The vast majority of these patients die of rupture of the aneurysm within five years after diagnosis. Approximately 10% of ruptures of thoracic aortic aneurysm present as aorto-esophageal fistula. Salvage is possible with prompt diagnosis and emergency surgical treatment, which consists of emergency aortic aneurysmectomy with dacron graft replacement utilizing the Crawford clamp and sew technique. Ideally, the esophagus should be resected with gastrointestinal continuity restored by esophagogastrostomy. Should this not be feasible, cervical esophagostomy with oversewing of the distal esophagus and placement of a tube gastrostomy can be utilized.

MANY PRACTICING PHYSICIANS apparently are unaware of the potentially grave consequences of thoracic aortic aneurysms. This, in part, stems from two deep-rooted medical fallacies that thoracic aortic aneurysms are usually clinically benign and rarely cause complications or death, and that most occur in older patients who are unlikely candidates for surgical repair. Fortunately, a wide experience by many cardiovascular surgeons has done much in the past two decades to dispel these dual myths. Certainly, the most vocal and most experienced of this group is Dr. Stanley Crawford. His vast experience reported in numerous articles in the surgical literature attest to the operability of this group of patients as well as the excellent surgical results that can be obtained.

Crawford has shown repeatedly that age *per se* is not a contraindication to surgery. In his series the age ranges from 19 to 86 years (50% were over 65 years of age).[1] The current surgical mortality is less than 10%, and the long-term outlook is certainly enviable when compared with the documented fatal rupture rate of 77% and a survival rate of only 13% at five years.[2] Additionally, Crawford has established that most thoracic aortic aneurysms can be surgically corrected without the use of a shunt or bypass.[3]

At least 10% of ruptures of thoracic aortic aneurysms occur into the esophagus. This condition is the most common cause of aorto-esophageal fistula.[4] However, a review of the literature revealed only two survivors following surgical treatment for thoracic aortic aneurysm presenting as an aorto-esophageal fistula. We have, therefore, elected to report our recent experience with a patient who presented at our institution with this interesting complication of a thoracic aortic aneurysm.

From the Department of Surgery, VA Medical Center, Jackson, MS.

Case Report

L. J. L., 51-year-old white male was admitted to the medical service of the Jackson VA Medical Center March 12, 1985. At that time he gave a two-day history of vomiting bright red blood. In addition, he

reported tarry stools for the past three days. A review of his last chest x-ray made in August 1983 revealed a dilated and tortuous thoracic aorta. His current chest x-ray demonstrated a large thoracic aortic aneurysm. He also complained of hypertension and angina. He had frequent headaches and took approximately 200 Anacin tablets per month. For this reason, the initial diagnosis was gastrointestinal bleeding, secondary to Anacin gastritis. On the day of admission, esophagogastroduodenoscopy (EGD) was scheduled but was abandoned because of acute ischemic EKG changes.

The following day he vomited a large amount of bright red blood, and an abdominal aortogram seeking the source of his gastrointestinal bleeding was ordered. In the x-ray department, the patient vomited a large amount of bright red blood and suffered a cardiac arrest. He was resuscitated and taken to the surgical intensive care unit to prepare for emergency surgery. EGD at this time revealed bright red blood that appeared to be "welling up from the stomach." At 28 cms from the oral incisors a mucosal irregularity was noted, but as there was no bleeding from this area, it was not thought to be the source of his current massive hemorrhage. Aorto-esophageal fistula was considered, but since this was not confirmed and as varices were ruled out, laparotomy for vagotomy and pyloroplasty was recommended. At laparotomy, minimal gastritis was noted. An empirical vagotomy and pyloroplasty was done.



Figure 1. Chest x-ray, August, 1983. The descending thoracic aortic aneurysm silhouette is clearly visible at the right cardiac border.

At the conclusion of the procedure, upon awakening, the patient again vomited a massive amount of bright red blood. He arrested and was successfully defibrillated four times. At this point, it was thought that he was bleeding from a vascular anomaly of the esophagus, and a Blakemore-Sengstaken tube was passed and inflated with immediate cessation of hemorrhage. Due to the chest x-ray evidence of a thoracic aortic aneurysm, a left thoracotomy was accomplished. However, the extreme tortuosity of the thoracic aorta as well as the massive size of the aneurysm, prevented confirmation of an aorto-esophageal fistula. As the bleeding remained quiescent, the left chest was closed, and the patient was returned to the surgical intensive care unit. He continued to bleed actively when the Sengstaken tube was deflated. For that reason, a right thoracotomy was accomplished on the following day.

A massive tortuous thoracic aortic aneurysm which pushed the mediastinum almost to the right lateral chest wall was encountered. This was resected between vascular clamps and replaced with a woven 22 mm dacron straight tube graft. No shunt or bypass was utilized. The esophagus was closed primarily. Consideration was given to distal oversewing of the esophagus and performing a cervical esophagostomy. However, this was not done because of the multiple prolonged operative proce-



Figure 2. Chest x-ray, March, 1985. The thoracic aortic aneurysm is now also visible in the right chest opposite the aortic arch. Note the marked increased size of the lower portion of the thoracic aortic aneurysm seen at the right cardiac border.

dures and the apparent adequate esophageal closure. Additionally, generalized esophageal cyanosis due to the Blakemore-Sengstaken tube being in place for over 24 hours was present, and it was thought that mobilization of the esophagus might lead to intolerable ischemia.

Following surgery, renal function was initially excellent, and there was no suggestion of neurologic impairment. His convalescence was marred by EKG evidence of a massive myocardial infarction and severe pulmonary insufficiency. He had severe chronic obstructive pulmonary disease, could not be weaned from the ventilator, and required a tracheostomy on his fifth postoperative day. On the tenth postoperative day he developed purulent chest tube drainage, and cultures grew *Klebsiella*. As he was ventilator-dependent and remained on vasopressors, further surgery was not performed. He succumbed on his 23rd post-operative day to sepsis.

Discussion

The two cases of successful surgical treatment of aorto-esophageal fistula due to ruptured thoracic aortic aneurysm were reported by Snyder and Crawford in 1983.[4] After dacron graft replacement of the aneurysm, each patient was treated by resection of the involved segment of esophagus. In one patient, continuity was restored by esophagogastrostomy. The other survivor was managed with cervical esophagostomy, distal oversewing of the esophagus, and tube gastrostomy. Certainly, the lesson to be learned from this experience is that the safest and most effective treatment of aorto-esophageal fistula is aneurysm repair combined with esophageal resection. Continuity is restored by esophagogastrostomy, if possible. If not, cervical esophagostomy and distal esophageal exclusion provides a viable alternative.

Undoubtedly, our patient developed esophageal necrosis related to the fistula, the Blakemore-Sengstaken tube-induced ischemia, and the surgical repair. Perhaps this complication could have been ameliorated by cervical esophagostomy and distal esophageal exclusion. Once mediastinal sepsis developed, this patient was not considered a candidate for esophagectomy and ascending aorta to abdominal aorta bypass (deemed necessary as we would have to assume associated infection of the dacron graft) because of severe pulmonary, cardiac, and renal failure.

It is interesting that the aneurysm was resected and the fistula repaired through the right chest instead of the customary approach via the left chest for a descending thoracic aortic aneurysm. The tortuosity involved in this case was truly monumental and, for that reason, resection and repair was fairly straightforward via right thoracotomy.

The initial chest x-ray showing an enlarged, dilated, or tortuous thoracic aorta should provide the alert physician the essential clue to the early diagnosis of upper gastrointestinal hemorrhage due to aorto-esophageal fistula. Given the luxury of time and patient stability, the thoracic aneurysm can be quickly confirmed by aortography. Esophagogastroduodenoscopy will readily demonstrate a mucosal irregularity at the fistula site. However, visualization of the aortic wall is usually fortuitously obscured by fresh blood clots. The typical patient will have a protracted history of dysphagia followed by significant episodes of unanticipated vomiting of large amounts of bright red blood. The bleeding usually spontaneously subsides, as it did in our patient, only to return at irregular periods for two to three days and finally terminate in one last massive exanguinating hemorrhage. It is during this "golden period" of quiescence after the first or "sentinel" bleed that effective efforts must be made to establish the diagnosis and expeditiously get the patient to the operating room for emergency correction of this rapidly fatal complication of thoracic aortic aneurysm.

It is generally agreed that virtually all descending thoracic aortic aneurysms can be repaired by approach through a left thoracotomy and graft interposition using the Crawford inclusion technique. No shunts or bypass are necessary.[3] A right radial arterial line is used for blood pressure monitoring and control, usually with nitroprusside. The morbidity and mortality resulting from this procedure is quite acceptable. Prompt surgical treatment results in greater than 90% survival and excellent long-term results. In patients presenting with signs and symptoms of a ruptured thoracic aortic aneurysm, including aorto-esophageal fistula, emergency surgery is recommended the same as for any ruptured aneurysm. Although the results of emergency surgery are poor as compared to elective surgery, they are acceptable in view of the zero survival which results from any other form of treatment.

Summary

1. A plea is made for prompt diagnostic intervention utilizing aortography in virtually all patients with chest-ray findings of "dilated," "ectatic," "tortuous," or frankly aneurysmal thoracic aorta.
2. The deadly nature of thoracic aortic aneurysms

must be recognized in time to recommend surgical therapy for these patients prior to developing a fatal complication such as aorto-esophageal fistula or other types of rupture.

3. Descending thoracic aortic aneurysms should be treated by the "clamp and sew" inclusion method of Crawford with the avoidance of shunts, extracorporeal bypass, and systemic heparinization.

4. Any patient with a known or suspected thoracic aortic aneurysm who presents with massive upper gastrointestinal hemorrhage should be considered to have an aorto-esophageal fistula until proven otherwise. Prompt diagnostic maneuvers, specifically, EGD, and, if necessary, thoracic aortography, followed by emergency operative intervention can truly be lifesaving.

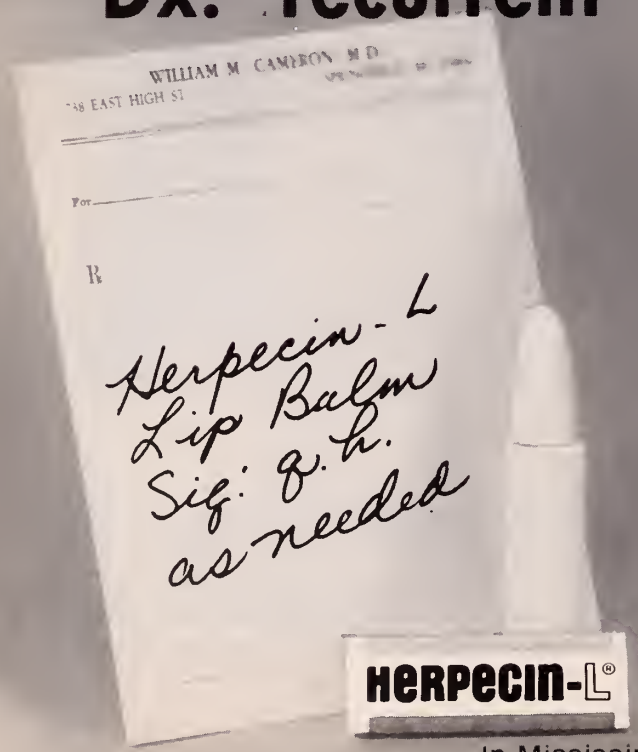
5. Surgical treatment of aorto-esophageal fistula should include esophageal resection of the involved segment once the aneurysm has been resected and replaced with woven dacron. Esophageal continuity is best restored by esophagogastrostomy. However, if this is not technically feasible, cervical esophagostomy, distal esophageal exclusion, and tube gastrostomy provide an acceptable alternative. ★★★

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Experience with Methacholine Inhalation Challenge in the Evaluation of Chest Symptoms

VICTOR E. SALTER, M.D.
Jackson, Mississippi

Chronic cough, vague chest discomfort and exertional intolerance are common and frequently difficult to evaluate and manage. The bronchial hyperreactivity seen in asthma can cause these symptoms and can be detected by methacholine inhalation challenge. Careful patient selection, a positive methacholine inhalation challenge, and improvement in symptoms on bronchodilators can make a diagnosis of asthma in such cases, according to the author.

Chronic cough, vague chest discomfort and exertional intolerance, complaints frequently seen in clinical practice, are difficult to evaluate and manage. A number of recent papers[1, 2, 3] have described asthma as a cause of these symptoms in the absence of wheezing and have demonstrated the ability of methacholine inhalation challenge to assist in making a diagnosis. Herein, we describe our technique for performance of methacholine inhalation challenge and present three patients in whom the results were helpful in diagnosis and management.

Method

Patients undergoing methacholine challenge initially perform routine spirometry with determination of FVC, FEV1, and FEV1/FVC. If FVC and FEV1 are 80% of predicted and FEV1/FVC is 70%, spirometry is considered normal and methacholine challenge is carried out. If baseline airway obstruction is present based on these criteria, the appropriate procedure is a bronchodilator challenge or a therapeutic trial of bronchodilators, not methacholine challenge.[4, 5]

In patients with normal spirometry, methacholine challenge is carried out using a protocol similar to that of Myers, Corrao, and Braman.[3] One to three inhalations of normal saline, from FRC to TLC, are performed using a De Vilbiss 646 nebulizer (the De Vilbiss Company, Somerset, Pennsylvania) driven with oxygen at a 7 liter per minute flow. Spirometry is performed at 1 and 3 minutes after nebulization with the post-saline FEV1 used as the baseline value for subsequent comparisons.

The initial methacholine chloride concentration is 5mg/ml with each breath giving 5 breath units (1 breath unit = 1 breath of a 1mg/ml solution). One breath is taken with spirometry performed at 1 and 3 minutes post-inhalation. A 20% fall in FEV1 indicates a positive response,[6] and further inhalations are not given. If a less than 20% fall in FEV1 occurs, increasing dosages of methacholine are given using the 5mg/ml solution and a 25mg/ml solution (see table) with spirometry again performed at 1 and 3 minutes. The challenge is continued until either a positive result is obtained or 190 breath units have been used. Lack of a positive response at 190 breath units is considered a negative challenge.[2, 3]

Case Reports

Case 1. A 39-year-old woman complained of one year of chronic cough with occasional mucoid sputum which began after a typical upper respiratory infection. She was seen by a number of physicians and was told she had bronchitis and received a variety of antihistamines, expectorants, antibiotics, and theophylline without benefit. On one occasion, a steroid injection resulted in relief for one week. An allergist evaluated her, felt she had no allergy, treated her with an inhaled beta agonist and inhaled steroid without results, and subsequently referred her to UMC.

From the Department of Medicine, Division of Pulmonary Diseases, University Medical Center, Jackson, MS.

Physical examination and routine pulmonary function tests were normal, as was a chest x-ray. Methacholine challenge was performed and at 140 breath units a nonproductive cough, substernal tightness, and a greater than 20% fall in FEV1 were noted. She was begun on an albuterol inhaler and prednisone 40mg daily.

Over the next month, it was necessary to increase the prednisone to 60mg daily. The cough was subsequently controlled, a beclomethasone inhaler was added, and prednisone was weaned to a low alternate day regimen. During the next several months, a mild cough persisted, but was much improved on therapy with inhaled and oral beta agonists, inhaled steroids, and alternate day prednisone.

Case 2. A 21-year-old male presented with a five-year history of dyspnea without wheezing or cough. His dyspnea was worsened by dry, dusty conditions and cigarette smoke, but was not affected by exercise, cold air or strong odors. He described chronic nasal congestion with postnasal drip worsened during exposure to pollens.

Physical examination and chest x-ray were unrevealing, and routine pulmonary function tests were normal. Methacholine challenge was carried out to 190 breath units without a 20% fall in FEV1.

He was reassured that he had no evidence of pulmonary disease and was given a long acting antihistamine-decongestant. Subsequent follow-up revealed marked improvement in his dyspnea and rhinitis. No symptoms of asthma have developed.

Case 3. An 18-year-old male presented acutely to an outside emergency room with dyspnea and vague chest pain worsened by breathing. He revealed to his local doctor a history of several months of exertional dyspnea and chest pain which necessitated his discontinuation of high school athletics.

Physical examination demonstrated only tachypnea, tachycardia, and anxiety. No abnormalities were noted on lung examination. Arterial blood gases demonstrated hypoxemia, mild hypercarbia, and mild acidemia. A chest x-ray was normal, but a perfusion lung scan demonstrated multiple subsegmental defects. He was begun on oxygen and heparin and referred to UMC for further evaluation.

Additional history obtained here revealed a cough on exposure to cold air, intolerance to strong odors, and a family history of asthma. Physical examination was unremarkable.

TABLE 1

Concentration	*Breaths*	*Total Breath Units*
5mg/ml	1	5
5mg/ml	2	15
25mg/ml	1	40
25mg/ml	2	90
25mg/ml	4	190

An echocardiogram, an impedance plethysmogram and a pulmonary arteriogram were obtained to rule out cardiac disease and venothromboembolism, and all were normal. Pulmonary function tests and arterial blood gases were normal.

An incremental exercise test using a cycle ergometer was performed, and after ten minutes of exercise, resulted in cough, substernal tightness and a 6% fall in FEV1. This suggested, but did not prove, exercise induced asthma, and methacholine challenge was performed. After 190 breath units, a 20% fall in FEV1 was observed.

He was placed on a albuterol inhaler 2 puffs 4 times daily and prior to exercise. He has suffered one additional episode of severe dyspnea, but responded to asthma therapy in his local emergency room. He still has occasional substernal chest pain, but has been able to resume athletics.

Discussion

Vague chest symptoms not readily explained by history, physical examination, and routine radiographic and pulmonary function studies are common clinical problems. Recent papers have demonstrated the ability of asthma, in the absence of wheezing, to be capable of producing these symptoms.[1, 2, 3] Methacholine challenge can demonstrate increased bronchial reactivity, which in combination with a response to asthma therapy makes the diagnosis.[2, 3]

Increased bronchial reactivity to methacholine is a highly sensitive method of detecting asthma,[7] is more reliable than a history of or the finding of wheezing when making a diagnosis,[5] and has been suggested as a criterion for making the diagnosis.[5, 7] Unfortunately, a positive methacholine challenge is not specific for asthma, having been found in normals, hayfever patients, COPD, and after viral upper respiratory infections.[7, 8] Generally, if one avoids testing patients with abnormal baseline function, history, physical examination, and radiographic evidence of other diseases, and also avoids use of higher doses of methacholine and requires a

clinical response to asthma therapy, confusion regarding the diagnosis can be avoided.[2, 3, 7, 9]

Summary

The difficult clinical problem of vague chest symptoms unexplained by routine evaluation is described. A method for further evaluation, the methacholine inhalation challenge, is described along with three patients in whom the technique was helpful. A discussion of the interpretation and limitations of methacholine inhalation challenge is given. ★★★

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Acknowledgement

Supported in part by a grant from the Mississippi Lung Association.

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Acromegaly: A Case Report

WILLIE L. WELLS, M.D.
Bruce, Mississippi

Long-standing untreated acromegaly results in progressive disfigurement, disability, and early death. The author presents a case report in which the patient experienced dramatic clinical improvement following transsphenoidal removal of a pituitary adenoma.

ACROMEGALY IS A SET of clinical features that result from an excess of growth hormone from autonomously-functioning pituitary adenomas or in others by hypothalamic derangement. Long-standing untreated acromegaly results in progressive disfigurement, disability, and early death. Insidious facial alterations occur over many years, including lengthening of the mandible, coarsening of facial features, and soft tissue overgrowth. Such an overgrowth produces widening of the nose, protrusion of the lips, and enlargement of the hands and feet. Hidradenitis, carpal tunnel syndrome, osteoarthritis, small airway narrowing, and diabetes mellitus may also occur. Cardiac hypertrophy and colonic polyps have also been more common in patients with acromegaly.

Case Report

L. B. is a 35-year-old white male who came to my office with a rash that he said he got every summer. The distribution of the rash included the face, arms, back, and chest. The rash proved to be tinea versicolor. The patient also described having continual heavy sweats as compared to other people he knew. He was curious as to why his hands were so large, having observed that his ring size had increased from a size 11 when he was in high school to a size 20 at the time of presentation. He stated that he had asked several physicians about his huge size and had been told he was just a big man. He denied visual disturbances, but did complain of facial pain, headache, and a long history of sinus problems. His only other complaint was that his feet and his hands frequently became numb.

Physical examination revealed a tall, large man (height 6′ 1″ and weight 260 lbs) with very coarse facial features — including a wide nose, forehead, and protruding jaw (see Figure 1). Another distinct feature was his very large hands and fingers, appearing to be twice the width of a normal man's. Blood pressure was 130/70, temperature 98.6, and pulse 82. He had a very hoarse-sounding voice. Pupils were equally round and reactive to light. Extraocular movements were intact, fundi were benign, and discs were sharp. Lungs were clear with normal breath sounds, and his heart had regular rate and rhythm without murmur.

The abdomen appeared normal, with no masses and positive bowel sounds. Neurologically, cranial nerves II-XII were intact, and reflexes were 1 + and symmetrical. There was good strength in all extremities, and he had normal visual fields. The hands had positive Phalen's and Tinel's signs for carpal tunnel syndrome (see Figure 2).

Laboratory data included fasting growth hormone 96.4 (normal adult less than 8) and glucose 105 fasting (normal 60-110).

Skull x-rays showed gross enlargement of the sella turcica with erosion of the floor of the sella consistent with a pituitary tumor. X-rays of the hands, taken four years earlier, were reviewed. They showed only early osteoarthritic changes in the P.I.P. and D.I.P. joints.

The patient was referred for transsphenoidal removal of his pituitary tumor, but surgery was delayed because of maxillary and frontal sinusitis. This condition was cleared with antibiotics and drainage with bilateral antrostomies and left frontal sinus trephine. Transsphenoidal surgery was done, with removal of a very large adenoma. It encompassed the entire gland, which made postoperative hormone replacement necessary. The only complication was a spinal fluid leak, which was resolved.

Growth hormone on discharge from the hospital was 8. The patient's replacement hormones consisted of cortisone acetate, thyroid, and halotestin.

Dr. Wells is engaged in the private practice of family medicine in Bruce, MS.



Figure 1. Preoperative photograph showing the patient's wide facial features.



Figure 2. The patient had large, wide hands. He presented with osteoarthritis and carpal tunnel syndrome.



Figure 3. Postoperatively, some reduction of soft tissue swelling is noted. Wide facial features are still present.



Figure 4. Postoperative photograph shows the patient's protrudng jaw.

He also received Diuril. He had significant decreased soft tissue swelling of the hands, feet, and face (see Figures 3 and 4). Pathology report revealed a neoplasm of fine granular eosinophilic cytoplasm.

Discussion

Acromegaly is a disease of gradual onset, with changes in facial and general features over a period of years. Old photographs may be helpful to identify such changes.

The patients may have dermatological changes, including skin thickening and sebaceous gland enlargement. Diabetes mellitus is found in 27% of acromegalic patients in some series. Osteoarthritis, visual field defects, cardiac hypertrophy, hypoxemia, and pneumomegaly may also occur. Some patients may present initially with carpal tunnel syndrome. Familial acromegaly has also been described.

The diagnosis of acromegaly is confirmed by measuring serum growth hormone (GH) after over-

night fasting or after an oral glucose tolerance test. Many patients possess random serum GH concentrations, which are so high as to be diagnostic. CT scans can be used to assess pituitary tumors. However, a simple skull x-ray may point out most macroadenomas.

Treatment may involve use of estrogens, medroxyprogesterone, antiserotonin agents, somatostatin, dopamine, and bromocriptine. Of the above, bromocriptine appears to be the most effective. However, a third of acromegalic patients do not respond to this drug.

Supervoltage irradiation has proven to be an effective treatment for acromegaly with no mortality and low morbidity; however, there is a delay in response and secondary hypopituitarism.

The therapy of choice appears to be transsphenoidal microsurgery with an approach to the pituitary for the removal of the adenoma. This restores the patient's GH to normal. Dramatic clinical improvement also occurs, with diminishing acromegalic features. Mortality rates range from nil to less than 2%.

Summary

The patient presented with many of the characteristic signs and symptoms of acromegaly. His facial features, hidradenitis, large hands with increased ring size, and carpal tunnel syndrome were only some of the features which a patient with acromegaly may present. The diagnosis was confirmed by demonstration of macroadenoma by skull x-rays and by his fasting growth hormone level. The diagnosis of acromegaly can be made simple by the above history, x-rays, and laboratory. Treatment may show a great improvement in the patient's clinical symptoms and prevent many future complications.

★★★

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The President Speaking

Hippocrates Revisited

Ralph L. Brock, M.D.
McComb, Mississippi

Many of you do not have to go back as far as I do to remember using the Oath of Hippocrates in connection with our Medical School graduation. The sense of accomplishment and unity we felt at that time has seldom been equaled in our professional career.

I am asking you to go back to that sense of unity we felt toward our fellow physicians and join in a combined effort to help preserve the practice of medicine that is so important to us.

Each member of the association has received a prospectus with a stock offer and letter of intent to participate in the MSMA-sponsored HMO/IPA. I hope that by now your component medical society or hospital medical staff has had a slide presentation explaining the project in detail. If not, contact MSMA headquarters to arrange for a presentation to be given in your area.

If there is ever a time we need to join together and coordinate our efforts, it is now. A frequently used method of marketing the PPOs is to pit doctor against doctor or hospital against hospital. We need to avoid that trap as we gather a necessary number of Mississippi physicians in a common cause. I can think of no better way to do this than use our membership in the Mississippi State Medical Association.

After the needed number sign up for the MSMA HMO/IPA, it is even more important that we think back to the days of our Hippocratic Oath. We need to put aside differences of specialty, geographic location, hospital affiliation and special interests. We can then sit down together and work out the many problems we will encounter in such a large undertaking. Most of the really difficult questions we will have to answer will be how we plan to deal with each other. But remember, it will be *our* group making the decisions, not some corporate office in New York, Chicago, or St. Louis.

I look forward to another day later this year when we can all feel a sense of unity and accomplishment almost matching the one I had in 1948. ★★★

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XXVII Number 1

January 1986

MSMA Physicians at Crossroads; Will We Lead or Follow?

Over the past two or three years numerous programs relating to alternative systems of delivering medical care have been sponsored by your society and other groups in Mississippi.

These programs were provided to inform you of what has taken place in other areas of the country, what was being proposed, and what the future holds for physicians practicing in Mississippi. From this it became evident that Mississippi physicians should not be passive regarding these changing events and that we would best be served by developing an active and aggressive plan for the future. In response, the MSMA House of Delegates passed a measure authorizing the Board of Trustees to investigate and develop a plan to structure a program to be sponsored by Mississippi physicians. After much study and deliberation, the Board of Trustees advised development of a statewide HMO/IPA. On December 5, 1985, the MSMA Board of Trustees proposed appointment of boards of directors for a statewide HMO and an IPA representing geographical areas of the state and most specialties.

The two newly appointed boards have met and with advice of legal counsel approved a prospectus to be furnished to each member of the association inviting their participation in this important venture. The prospectus deserves your thoughtful consideration and strong support. Mississippi physicians are now at a crossroads. We can actively participate in developing a strong physician-directed program sponsored by the MSMA or we can sit idly by and watch other groups develop alternative systems for delivering medical care in Mississippi with little physician input.

With any study of current health care issues, it becomes obvious that changes are going to occur. These changes will not be stopped by physician resistance or refusal to accept and undergo modifications in the way we practice medicine. With involvement in an MSMA-sponsored HMO/IPA, we have the opportunity to lead rather than follow. Such a program can be structured to preserve the existing physician-patient relationship as much as possible; far more so than in programs sponsored by other groups.

Do not place this matter on the back of your desk. It requires a thoughtful response. If there are questions, ask for clarification or elaboration. Your input at all levels will be helpful and necessary. With such a response we can improve the delivery of health care to the citizens of Mississippi and have an impact on the future of our profession.

Myron W. Lockey, M.D.
Editor

Medico-Legal Brief

Husband Of Jehovah's Witness Who Refused Blood Transfusion Sues Physician For Malpractice

A physician was not released from liability for negligence by a patient's refusal to receive a blood transfusion, the Washington Supreme Court ruled.

The physician recommended that the patient have a D&C after diagnosing a missed abortion. The physician did not discuss alternative methods of performing the procedure, but advised the patient that she might bleed during the procedure. The patient sought a second opinion and was advised that the D&C was the appropriate treatment. The second physician also advised the patient of the possibility of bleeding.

The patient and her husband, who were Jehovah's Witnesses, signed a form refusing to permit blood transfusions and releasing the hospital and physician from responsibility for unfavorable results due to this refusal. During the operation, the physician severely lacerated the patient's uterus. The patient began to bleed profusely. She was coherent at the time, and she and her husband both refused permis-

(Continued on page 25)

ASSURANCE Of A Firm Foundation

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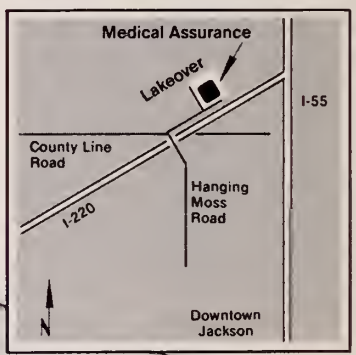
Because of this phenomenal growth, we recently had to move to larger quarters in order to house the necessary staff and facilities to provide even better service.

For answers to any questions you might have regarding medical malpractice insurance, feel free to come by our new office or call on us at any time.

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Groundbreaking Ceremonies Held; MSMA Office Construction Begins

Groundbreaking ceremonies held last month marked the beginning of construction for MSMA's new headquarters office building.

The structure, which will also house the MSMA Auxiliary, the Medical Assurance Company of Mississippi, and the Mississippi Foundation for Medical Care, will be erected at the front of the existing building on Riverside Drive. In addition to the expansion, plans also call for complete renovation of the existing building. The project is scheduled to be completed by January 1, 1987.

Designed by Cooke, Douglass, Farr, Ltd. of Jackson, the three-story addition will feature reflective glass curtain walls, stone panels and brick, and will have glass block highlights. Jones and Thompson Construction Co., Inc. of Jackson is building the complex, which will have more than 30,000 square feet. The structure will accommodate a fourth floor, which can be added for future growth of the occupant organizations.

The MSMA House of Delegates approved the building program at the 1984 Annual Session based on recommendations of the Board of Trustees. Architects were subsequently retained to begin the design phase of the proposed building, and negotiations were completed to obtain necessary parking on state and city property adjacent to the existing MSMA building. The Board of Trustees presented a status report on the building program at the 1985 Annual Session, and the House of Delegates directed that the project proceed.

Present plans call for the $2 million construction project to be financed through a syndicated limited partnership offered to MSMA members only. This offering will occur early this year.



MSMA officers and Board of Trustees members were present at groundbreaking ceremonies last month, when construction of the new MSMA office complex got underway. Pictured, from left, are: Dr. Ellis Moffitt; Dr. Jimmy Waites; Dr. Bernard Hunt; Dr. David Steckler; Dr. Faser Triplett, president of Medical Assurance Company of Mississippi; Dr. Ralph Brock, MSMA president; Dr. W. Joseph Burnett; Dr. Roy Duncan, chairman of the MSMA Board of Trustees; Dr. Sidney Graves; Mr. Bill Cooke of Cooke, Douglass, Farr, Ltd. of Jackson; Dr. Lee Rogers; Dr. Martin McMullan; Dr. Elmer Nix; Dr. Ed Hill; Mr. David Patterson of Cooke, Douglass, Farr, Ltd. of Jackson; Dr. Carl Evers; Dr. David Owen; Dr. C. G. Sutherland; and Mr. Bill Jones of Jones and Thompson Construction Co., Inc. of Jackson.

Pioneer Physician Honored By Mississippi Orthopedic Society



Dr. Thomas H. Blake of Jackson, second left, was honored for his contributions in pioneering orthopedics in Mississippi at the first annual fall meeting of the Mississippi Orthopedic Society and its Jackson Chapter. Pictured also are Dr. J. Elmer Nix, Mississippi counsilor to the American Academy of Orthopedic Surgeons, left; The Honorable Wayne Dowdy, Fourth District Congressman; and Dr. Alan E. Freeland, president of the Mississippi Orthopedic Society.

Doctor, Do You Know . . .

That 1246 Auxilians are working for you right now? Much More Can Be Done.

At no time in the history of the medical profession have we seen such massive changes taking place. As DRGs, PPOs, PROs, and HMOs and all of the various alternative systems of health care delivery become more and more common — as competition for patients increases, as the threat of malpractice litigation becomes more prevalent, we see the practice of medicine changing before our eyes.

More than ever before, our Auxiliary needs to increase its membership, unite, and commit its assistance to the medical profession in response to these changes affecting our medical environment.

The strength of any organization is in its membership. We need auxiliary members and their personal commitment now so that we can help influence the future direction of medicine in our communities.

Please pay MSMA Auxiliary and AMA Auxiliary dues for your spouse

UMC Announces Faculty Changes

Dr. David L. Bruce has been named chairman of the Department of Anesthesiology at the University of Mississippi Medical Center.

Dr. Bruce, who is professor of anesthesiology of the School of Medicine and professor of nurse anesthesiology in the School of Health Related Professions, is among three named in appointments and two in promotions in the medical, nursing, dental and health related professions schools for the current academic session.

The appointments were announced by Dr. Norman C. Nelson, vice chancellor for health affairs, following approval by the Board of Trustees of the State Institutions of Higher Learning.

A member of the Medical Center faculty since 1984, Dr. Bruce was professor of anesthesiology at New York University from 1981-1984, and at the University of California at Irvine from 1977-1981. He earned the M.D. degree in 1960 at the University of Illinois and completed his residency at a postdoctoral fellowship in 1964 at the University of Pennsylvania. Before his faculty appointment at the University of California, Dr. Bruce had been on the faculty of Northwestern University in Evanston, Illinois, for 11 years, and was professor of anesthesia and doctor of research in anesthesia. He was instructor in anesthesiology at the University of Kentucky from 1964-1965. A fellow of the Royal Society of Medicine in England, he was awarded a traveling fellowship by the Royal Society of Medicine in 1975, and has held visiting professorships in the U.S. and abroad. Dr. Bruce had served as acting chairman of the Department of Anesthesiology since November, 1984.

Rebecca J. Yates was also named this month to head a department on the health sciences campus. She will chair the Department of Medical Record Administration in the School of Health Related Professions. In other UMC appointments, Eloise Bell was appointed instructor in emergency medical technology, Jane A. Rivlin an instructor in nursing, and Dr. Aaron Trubman an associate professor of community and oral health.

Yates has served as acting chairman of medical record administration since January, 1985. She earned the B.A. in 1968 and the master's in education in 1972 at Mississippi College. She received the certificate in medical record administration in 1969 from UMC, becoming an instructor in the training program for medical record librarians. In 1971, she was named interim director of the program, and codirector, 1972-1973. Ms. Yates has been associate professor of medical record administration in the health related professions school since 1980.

A 1977 graduate of the University of Southern Mississippi, Ms. Bell was instructor in obstetric nursing and clinical instructor in medical-surgical nursing from 1978-1979 at Pearl River Junior College, and instructor in emergency medical technology from 1978-1982 in the Vo-Tech Division, while a medic with the Southeast Air Ambulance District. She also was nurse manager in emergency services at Methodist Hospital in Hattiesburg before coming to the Mississippi Baptist Medical Center in Jackson as head nurse in emergency services. She has been instructor in emergency medical technology at Jones County Junior College in the Vo-Tech Division since 1983.

Ms. Rivlin earned the B.S.N. in 1975 at Vanderbilt University and the master's in nursing in 1978 at Boston College. She was on the nursing staff at Vanderbilt University Medical Center from 1975-1977, and at Huntington General Hospital in Boston, Massachusetts, until 1979, when she came to the Medical Center as instructor in nursing for three years.

Dr. Trubman earned the D.D.S. in 1950 at Temple University in Philadelphia, Pennsylvania. He holds a master's in public health from the University of North Carolina at Chapel Hill. On the UMC clinical faculty since 1978, he has been administrator for the Division of Public Health Dentistry for the Mississippi State Board of Health since 1960. He practiced privately in Philadelphia for two and a half years, and has been a dental officer in the U.S. Navy and the U.S. Public Health Service Reserve.

MSMA
118th Annual Session

June 4-8, 1986
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Mark Your Calendar Now!

PERSONALS

James Achord of UMC was guest speaker at the Northwest Louisiana Society of Family Physicians in Shreveport, and presented grand rounds at the Laukenau Hospital in Philadelphia, Pennsylvania.

Erlinda Alcalen of Bay St. Louis has associated with Diamondhead Medical Clinic for the practice of obstetrics and gynecology.

J. Gilbert Alexander of Union has been recertified as a diplomate of the American Board of Family Practice.

Orlando Andy of UMC lectured as visiting professor at the Medical College of Pennsylvania in Philadelphia.

Michael Boler has associated with Brett T. Person of Greenwood for the practice of internal medicine.

Leonard H. Brandon of Starkville has been recertified as a diplomate of the American Board of Family Practice.

Sidney O. Brown announces the opening of his office for the practice of family medicine at 4300 Arkansas Avenue in Gulfport.

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Weir Conner of Jackson spoke at Northside Elementary School at a program to help teachers and parents identify children and adolescents with attention deficit disorders.

David Crawford of UMC presented a scientific exhibit at the 79th annual scientific assembly of the Southern Medical Association in Orlando, Florida, and chaired a meeting of the executive committee of the Intergroup Prostate Protocol in Bethesda, Maryland.

R. W. Crowell of Jackson announces his retirement from the practice of medicine.

Edgar Dapremont of Gulfport has been elected a fellow of the American College of Surgeons.

J. T. Davis of Corinth and Mrs. Davis have been honored by their son with the establishment of a scholarship to assist University of Mississippi students in pursuing medical degrees.

Owen Evans of UMC was examiner for the American Board of Psychiatry and Neurology in Chicago, and was guest speaker at pediatric grand rounds at the University of Texas Health Sciences Center in San Antonio.

O. Lynn Hamblin of Calhoun City has been named a fellow of the American Academy of Family Physicians.

Martin I. Herman of Tupelo is participating in a task force to study and plan a victim assistance program for Northeast Mississippi.

Julian B. Hill of Tupelo attended the Clinical Community Oncology Program's Ad Hoc Advisory Committee meeting in Bethesda, Maryland.

Jeff A. Hodges of Pascagoula has been named chief of staff at Singing River Hospital. Other officers are Edgar W. Hull, chief-elect, and Theodore M. Millette, secretary-treasurer.

James Hughes of UMC recently taught a continuing education course in Sea Island, Georgia.

Michael E. Jabaley of Jackson was keynote speaker at a meeting in New York City of the New York Society for Surgery of the Hand.

Thomas K. Judd of Laurel announced the association of Michael Ruth for the practice of gastroenterology.

(Continued)

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Forrest General Hospital in Hattiesburg has taken a major step forward in coronary care. With the addition of a skilled cardiovascular surgeon and experienced surgical team, Forrest General now provides open heart surgery, including coronary bypass and valve replacement procedures. This important surgical back-up also enables our cardiology team to offer Percutaneous Transluminal Coronary Angioplasty, an alternative treatment for arterial blockage.

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FORREST GENERAL HOSPITAL

PERSONALS/Continued

Kim Kirkland announces the opening of his office for the practice of family medicine at 305 Ellis Street in Carthage.

Robert A. Little of Gulfport was elected president of the Tulane Medical Alumni Association.

James B. Martin of Ocean Springs has been elected chief of staff at Ocean Springs Hospital. Other officers are John Drake, chief-elect, and Charles P. Stroble, secretary-treasurer.

G. Rodney Meeks of UMC made a presentation at the Academy of Family Medicine meeting in Knoxville, Tennessee.

Robert Middleton of Biloxi has been recertified as a diplomate of the American Board of Family Practice.

Francis Morrison of UMC was a site visitor for the Southwest Oncology Group at Tulane University in New Orleans.

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William Nicholas of UMC spoke to health care professionals and the general public at the VA Medical Center on the subject of diabetes.

Peter H. Oostwouder of Heidelberg has been named a diplomate of the American Board of Family Practice.

Charles J. Parkman of Hattiesburg has been elected president of the Mississippi Thoracic Society. Other officers are William C. Pinkston, president-elect, and James E. Griffith, president.

William Preau has associated with J. Richardo Merlos of Pascagoula for the practice of anesthesiology.

George Purvis of Jackson received Mississippi College's "Order of the Arrow" award presented to outstanding alumni.

Alfio J. Rausa of Greenwood has been named recipient of the 1985 Underwood Award for outstanding contributions in public health.

Ben Sanford of Starkville was featured speaker at the Oktibbeha County Hospital Auxiliary meeting.

Barbara L. Smith has associated with Frederick Bradshaw of Greenwood for the practice of anesthesiology.

Randy Voyles of Jackson presented a scientific exhibit at the annual meeting of the American College of Surgeons in Chicago.

Robert Watson of UMC attended the Atherosclerosis Risk in Communities Study (ARIC) steering committee meeting in Bethesda, Maryland.

Lamar Weems of UMC spoke to the Vicksburg Rotary Club recently.

Gerald Wessler of Gulfport announces his retirement from the practice of urology.

SCIENTIFIC EXHIBITORS

A few exhibit spaces are still available for the scientific exhibit at MSMA's 118th Annual Session, June 4-6, 1986, in Biloxi.

To apply, send a letter describing the exhibit, furnishing name(s) of exhibitor(s), title, and estimated linear feet required for the display to MSMA, Box 5229, Jackson, MS 39216.

Mississippi State Medical Association Auxiliary

Reaching Out

This year I chose as a theme for the MSMA Auxiliary the concept of "Reaching Out." When you hear the term "reaching out" what comes to your mind? You as physicians reach out daily to your patients' physical and emotional needs, and to family and civic duties as well. Those of us in the auxiliary want to reach out to our spouses, our families, our friends, and our communities. Through activities offered by the medical auxiliary we are able to accomplish some of these goals.

As a group, we are very much like a "family" and as a family, we have special needs. Many of the auxiliary's attempts to "reach out" so far this year have been addressed toward our family's special needs in the areas of drug- and alcohol-impaired physicians and medical liability cases and the effects of both these tragedies on the physician and his family. Efforts are underway to develop support groups for physicians and their families facing a medical liability suit.

In addition, individual county auxiliaries have "reached out" to legislators at a local level, instead of at a more impersonal statewide meeting. At these get-togethers we have attempted to strengthen medicine's voice with these important individuals, realizing that the time has come to capitalize on nationwide efforts to curb unreasonable medical liability awards.

Emphasis has also been placed on "reaching out" to non-members to increase membership in MSMAA. This effort was greatly enhanced over the past few years by the willingness of the MSMA to include the auxiliary dues on the physician's statement of dues.

As we begin a new year, I look forward to an increase in interest and participation by auxiliary members, and to a continuing good relationship with MSMA, because *you* are the reason for our being. ★★★

Mrs. Ben F. Martin
MSMAA President

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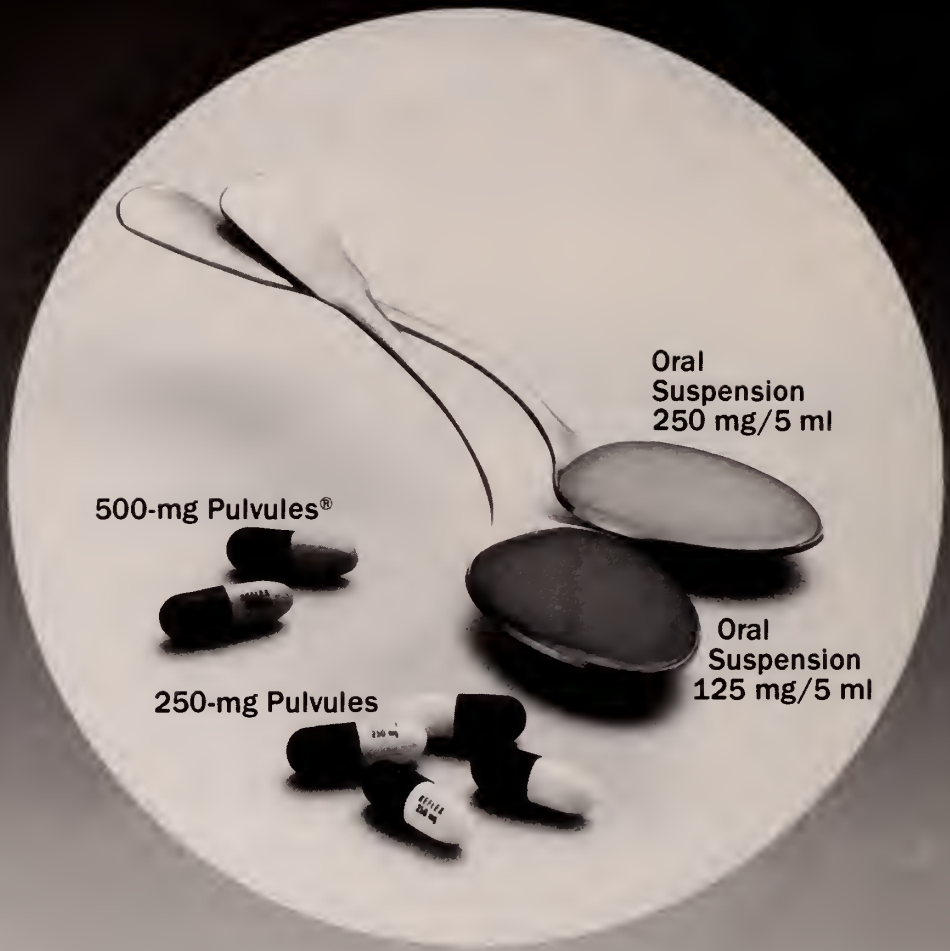
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NEW MEMBERS

Carpenter, Don E., Jackson. Born Hattiesburg, MS; Oct. 15, 1954; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned and neurology residency, University Medical Center, Jackson, 1979-84; electromyography and electroencephalography fellowship, same 1983-84; elected by Central Medical Society.

Connors, John J., III, Jackson. Born April 21, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1975; radiology residency, University Medical Center, Jackson, 1975-78; elected by Central Medical Society.

Cooley, Daniel Jay, Columbus. Born Herkimer, NY, Jan. 27, 1934; M.D., Loma Linda School of Medicine, CA, 1960; interned Myer Memorial Hospital, Buffalo, NY, one year; elected by Prairie Medical Society.

Dockery, Melissa H., West Point. Born Ruleville, July 19, 1955; M.D., University of Mississippi School of Medicine, Jackson, 1982; interned and family practice residency, University of Tennessee, Knoxville, 1982-85; elected by Prairie Medical Society.

Estess, Robert E., Clinton. Born Hinds, MS, July 27, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1975; family medicine residency, University Medical Center, Jackson, 1975-78; elected by Central Medical Society.

Ferguson, Mitzi Gail, Jackson. Born Pontotoc, MS, Dec. 22, 1954; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned, pediatric residency, and neonatology fellowship, University Medical Center, Jackson 1980-85; elected by Central Medical Society.

Field, Richard J., III, Centreville. Born Jacksonville, FL, Feb. 26, 1952; M.D., Tulane University School of Medicine, New Orleans, 1979; interned, general surgery, and traumatic orthopedic surgery residency, Charity Hospital, New Orleans, 1979-85; elected by Amite-Wilkerson Medical Society.

Garretson, Roland F., Jr., Jackson. Born Mobile, AL, March 24, 1957; M.D., University of Mississippi School of Medicine, Jackson, 1982; interned and medicine residency, University of Arkansas, Little Rock, 1982-85; elected by Central Medical Society.

Giffin, Robert Lee, Vicksburg. Born Louisville, MS, May 31, 1956; M.D., University of Mississippi School of Medicine, Jackson, 1982; interned and family practice residency, University Medical Center, Jackson, MS., 1982-85; elected by West Miss. Medical Society.

Grimes, Ben M., Meridian. Born Geneva County, AL, Oct. 5, 1935; M.D., University of Alabama School of Medicine, Birmingham, 1963; interned Caraway Methodist Hospital, Birmingham, one year; medicine residency, Mayo Clinic, Rochester, MN, 1964-67; pulmonary medicine residency, University of Alabama, Birmingham, 1971-72; anesthesiology residency, same, 1982-84; elected by East Mississippi Medical Society.

Gutterman, John S., Columbus. Born Hackensack, NJ, Dec. 9, 1954; M.D., State of Mexico University, Mexico, 1977; interned Hahnemann University, Philadelphia, PA, one year; anesthesiology residency, University of Tennessee, Memphis, 1981-83; elected by Prairie Medical Society.

Hendrick, Richard G., Corinth. Born Tupelo, MS, Dec. 3, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned and medicine residency Methodist Hospital, Memphis, 1977-80; elected by Northeast Mississippi Medical Society.

Hines, Brenda P., Jackson. Born Freeport, TX, Aug. 29, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1982; interned and family practice residency, University Medical Center, Jackson, 1982-85; elected by Central Medical Society.

Hogan, Reed B., II, Jackson. Born Clarksdale, MS, April 16, 1955; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned and medicine residency, University Medical Center, Jackson, 1981-84; gasteroenterology residency, Baylor University Medical Center, Dallas, one year; elected by Central Medical Society.

Jones, Virginia Ann, Jackson. Born Jackson, May 12, 1946; M.D., University of Tennessee Center for Health Sciences College of Medicine, Memphis, 1981; interned one year, University of Tennessee, Memphis; ob-gyn residency, Crump Women's Hospital, Memphis, 1982-85; elected by Central Medical Society.

Lambuth, Bruce W., Jackson. Born Jackson, Sept. 10, 1952; M.D. University of Mississippi School of Medicine, Jackson, 1978; interned, medicine residency, and oncology residency, University Medical Center, Jackson, 1978-85; elected by Central Medical Society.

Long, Richard L., Picayune. Born Fayetteville, AR, Aug. 6, 1950; M.D., West Virginia School of Osteopathic Medicine, Lewisburg, WV, 1984; interned Selby General Hospital, Marietta, OH, one year; elected by Pearl River Medical Society.

Lucas, Phillip H., Jackson. Born Levelland, TX, July 9, 1949; M.D., University of Texas School of Medical, Medical Branch at Galveston, 1975; interned and medicine residency, Scott & White Memorial Hospital, Temple, TX, 1975-78; radiology residency, Baptist Memorial Hospital, Memphis, 1981-84; elected by Central Medical Society.

Mangum, Charles S., Jackson. Born Vicksburg, MS, July 9, 1955; M.D., University of Mississippi School of Medicine, Jackson, 1982; interned Baptist Hospital, Memphis, 1982-83; anesthesiology residency, University Medical Center, Jackson, 1983-85; elected by Central Medical Society.

Maples, Michael D., Jackson. Born Biloxi, Feb. 27, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned and general surgery residency, Vanderbilt University, Nashville, 1977-83; cardiovascular fellowship, same, 1983-85; elected by Central Medical Society.

Martin, Rick W., Jackson. Born Crosbyton, TX, March 22, 1951; M.D., University of Texas Medical Branch, Galveston, 1977; interned and ob-gyn residency, same, 1977-81; elected by Central Medical Society.

Nolan, Rathel L., III, Jackson. Born Long Beach, CA, Jan. 9, 1955; M.D., University of Mississippi School of Medicine, Jackson, 1982; interned and medicine residency, University Medical Center, Jackson, 1982-85; elected by Central Medical Society.

Oostwouder, Peter H., Heidelberg. Born Sioux City, IA, June 27, 1956; M.D., St. Louis University School of Medicine, St. Louis, MO, 1982; interned and family practice, United Hospital, Clarksburg, WV, 1982-85; elected by South Mississippi Medical Society.

O'Sheal, Steven F., Hattiesburg. Born Philadelphia, PA, Nov. 5, 1954; M.D., Vanderbilt University School of Medicine, Nashville, 1981; interned and pathology residency, Parkland Memorial Hospital, Dallas, 1981-85; elected by South Mississippi Medical Society.

Peeples, Alan R., Jackson. Born Malvern, AR, June 30, 1955; M.D., University of Arkansas School of Medicine, Little Rock, 1982; interned and anesthesiology residency, University Medical Center, Jackson, 1982-85; elected by Central Medical Society.

Pisharodi, Madhavan A., Columbus. Born India, July 13, 1945; M.D., India, 1967; Neurosurgery residency, University of Texas, Galveston, 1980-84 and Lutheran Medical Center, New York, NY, 1984-85; elected by Prairie Medical Society.

Smith, L. Douglas, Natchez. Born Ferriday, LA, Feb. 20, 1954; M.D., Louisiana State University School of Medicine, New Orleans, 1980; interned Charity Hospital, New Orleans, one year; ophthalmology residency, Ochsner Medical Foundation, New Orleans. 1981-84; elected by Homochito Valley Medical Society.

Sorey, William H., Jackson. Born Mobile, AL, Aug. 13, 1957; M.D., University of Mississippi School of Medicine, Jackson, 1982; interned and pediatric residency, University Medical Center, Jackson, 1982-85; elected by Central Medical Society.

Roman, Jose L., Marks. Born Manila, Philippines, Nov. 2, 1957; M.D., Boston University School of Medicine, Boston, MA, 1982; interned and medicine residency, St. Vincent Hospital, Worchester, MA, 1982-85; elected by Clarksdale & Six Counties Medical Society.

Williams, Charles H., Canton. Born Jackson, MS, July 17, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned and family practice residency, Spartanburg, SC, 1978-81; elected by Central Medical Society.

Wilson, James P., Meridian. Born Meridian, MS, May 25, 1955; M.D., University of Mississippi School of Medicine, Jackson 1981; interned, pediatric residency and adolescent fellowship, University Medical Center, Jackson, 1981-85; elected by East Mississippi Medical Society.

Wilson, Rhonda S., Meridian. Born Hattiesburg, MS, Nov. 22, 1956; M.D., University of Mississippi School of Medicine, Jackson, 1981; interned and medicine residency, University Medical Center, Jackson, 1981-85; elected by East Mississippi Medical Society.

Medico-Legal Brief

(Continued from page 13)

sion to give her a transfusion. She bled to death.

The patient's husband brought a wrongful death action alleging that the physician's negligence proximately caused the patient's death. The jury found the physician negligent and that his negligence was a proximate cause of the patient's death. However, the jury found that the patient and her husband knowingly assumed the risk of bleeding to death and attributed 75 per cent of the fault for her death to the refusal to permit blood transfusions, reducing the damages awarded from $412,000 to $103,000.

On appeal, the court found the refusal to permit transfusions to be valid and that the document was signed voluntarily. However, the court disagreed with the physician's assertion that the refusal acted as a complete bar to the wrongful death claim. The court pointed out that while the patient and her husband accepted the consequences resulting from a refusal to have a blood transfusion, they did not accept the consequences of the physician's negligence. The court affirmed the lower court's judgment. — *Shorter v. Drury,* 695 P.2d 116 (Wash. Sup.Ct., Jan. 11, 1985)

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For asymptomatic persons the Society recommends annual digital rectal examination at age 40 and over; at age 50 and over, an annual stool blood test, as well as sigmoidoscopy every three to five years, following two initial annual negative sigmoidoscopies.

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RECOLLECTIONS

Ten years ago, MSMA president Jack A. Atkinson, M.D., commented in his January 1976 president's page article on the implementation in Mississippi of the Health Planning and Resources Development Act of 1975. He urged adequate representation by practicing physicians on the governing board of the health systems agency slated for the state.

He also noted, "From the vantage point of well over a quarter of a century involvement in the practice of medicine, I have witnessed a continuous evolution toward a better quality of health care in this country. And today I must agree . . . that more people are receiving better care by better trained doctors than ever before in the history of our nation. It is difficult for me to understand, therefore, why so many of our congressional leaders insist that abandonment of our present health care system is necessary and why they think the system must be restructured and reorganized."

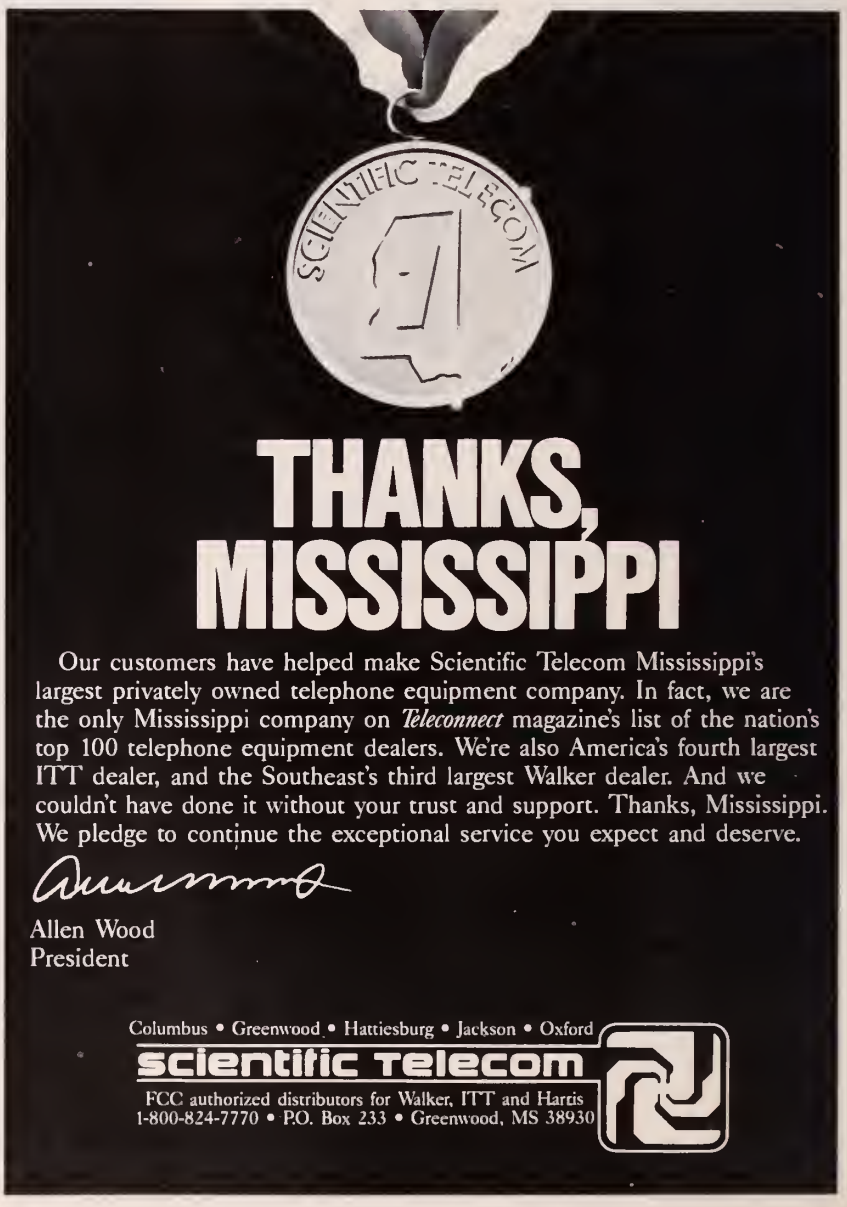
Dr. Atkinson's editorial included the quotation, "We trained hard but it seemed that every time we were beginning to form into teams we would be reorganized. I was to learn later in life that we tend to meet any new situation by reorganizing. And a wonderful method it can be for creating the illusion of progress while producing confusion, inefficiency, and demoralization." That quote was from a speech by Petronieus Arbiter, delivered in Rome some 2,000 years earlier.

That issue of JOURNAL MSMA included a note that future issues would include articles on the history of medicine in Mississippi as part of the celebration of the nation's bicentennial.

The issue reported on the association's Board of Trustees December meeting, which included a full agenda of business. Among Board actions was a direction to release to the Mississippi Medicaid Commission a peer review report concerning quality and efficiency of services provided by physicians in the state. The Board reviewed the association's legislative recommendations, most of which dealt with the growing professional liability crisis in the state. The Board also approved the association's participation in a "Mississippi Health Care forum" to be co-sponsored by other health professional groups and a "Mississippi Quality of Life Conference" slated for 1977.

Scientific articles in that issue included: "Problems in Abdominal Surgery: Peritoneovenous Shunting for Intractable Ascites" by William O. Barnett, M.D. of Jackson, and "Trans T-Tube Extraction of Retained Biliary Stones," by Jeff Hodges, M.D. of Pascagoula.

Twenty years ago, a JOURNAL MSMA editorial commented on the importance of voluntary programs of health services, research, and education, and noted the role of the MSMA Council on Medical Service in providing physician guidance in those activities. The article dealt with the AMA's policy statement that "the medical society has an implied responsibility for citizen groups who are interested in the promotion and maintenance of health" and predicted a new era of mutuality for medicine and voluntary health agencies.





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The Mississippi Disability Determination Services now has a program available for medical society meetings and hospital staff meetings. The purpose of this program is to explain how the disability determination process works, its historical background, its basis in legality and its documentation requirements. Any group interested in this presentation should also contact the Medical Relations Office.

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Index to Advertisers

Ayerst Laboratories **10A, 10B, 10C, 10D**

Campbell Laboratories 4
Canton Exchange Bank 18
Curtis 1000 Information Systems **12**

Disability Determination Service **13**

Eye Foundation **10**

Forrest General Hospital 19
Future Systems 8

Harreld Chevrolet 7

Eli Lilly and Co. 22B

Ralph Maisel 25
Medical Assurance Co. of Miss. 14
MSMA Benefit Plan and Trust ..... **second cover**

Premier Printing 20

Roche Laboratories ..... **third, fourth covers**

Scientific Telecom 26

Trans Union Credit Information 22

University of Alabama **4, 5**
The Upjohn Co. 22A
U. S. Air Force 27
U. S. Army Reserve **6**

Jon Wimbish **8**

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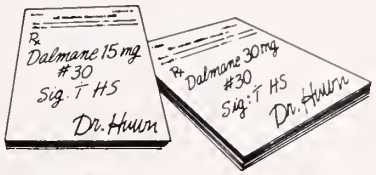
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References: **1.** Kales J, *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A, *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A, *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A, *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Dement WC, *et al: Behav Med*, pp 25-31, Oct 1978. **7.** Kales A, Kales JD: *J Clin Psychopharmacol 3*:140-150, Apr 1983. **8.** Tennant FS, *et al*: Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984. **9.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977



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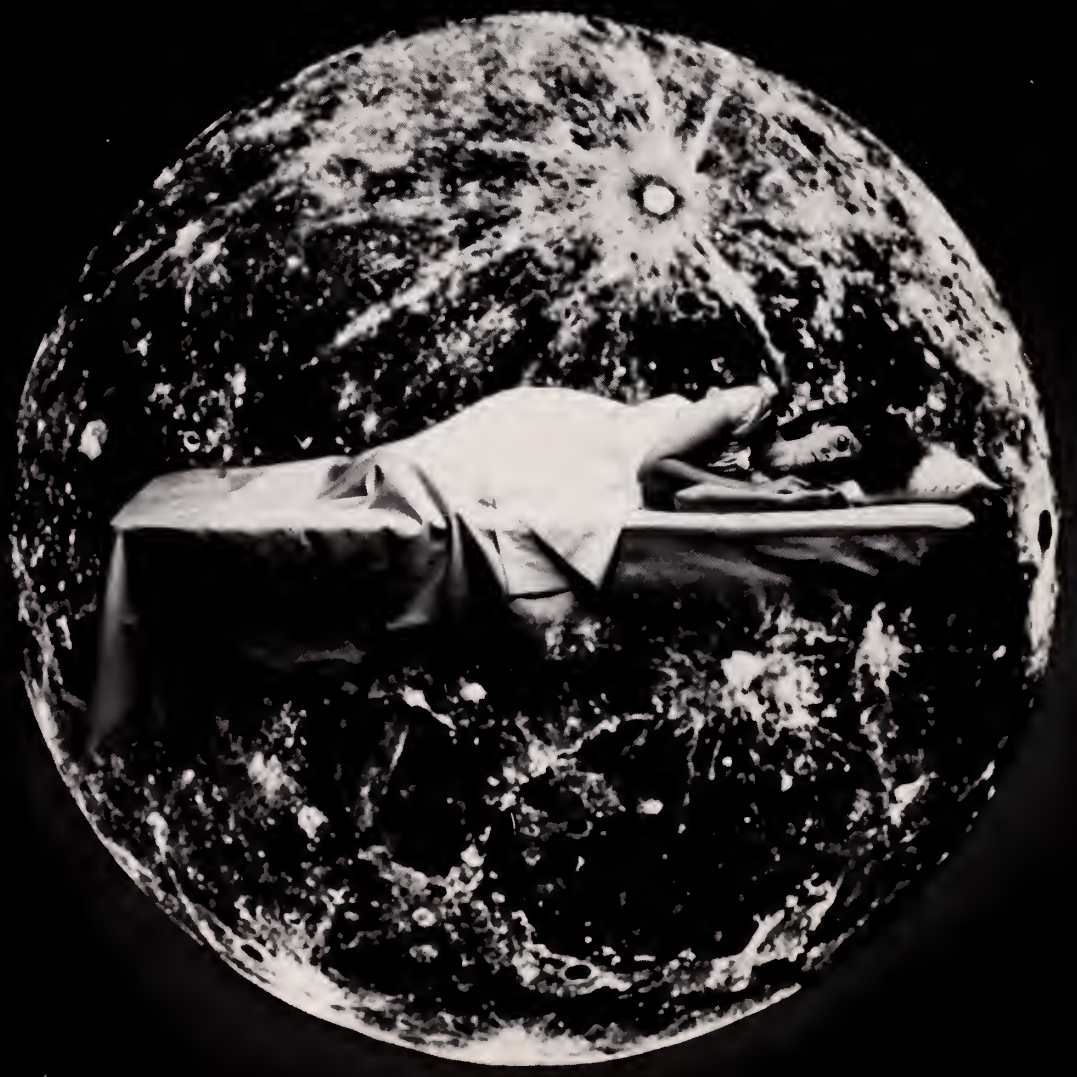
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CONTENTS

ORIGINAL PAPERS

Cat Scratch Encephalopathy **29** Anna Wright, John Moffitt, M.D., and Owen B. Evans, M.D.

Adverse Drug Reaction Reporting by Mississippi Physicians **33** John P. Juergens, R.PH., PH.D. and Benjamin F. Banahan, III, PH.D.

SPECIAL ARTICLE

Ob-Gyn Grand Rounds: Management of Ectopic Pregnancy **39** Bryan D. Cowan, M.D.

EDITORIAL

Airport — 1986 **43** Joe Johnston, M.D.

THIS MONTH

The Water's Fine **42** The President Speaking
44 Comment
45 Medico-Legal Brief
47 Medical Organization
52 New Members
50 Deaths
55 Personals

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NEWSLETTER

February 1986

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> An abundance of basic information is included in the pamphlets: who needs food supplements and recommended amounts...what sodium levels are present in common foods...special dietary needs for varying age levels...the most common forms of food poisoning and steps to follow in preventing illness...a guide to practical weight reduction.
>
> The inexpensive Food and Nutrition Pamphlet Sets are available from the Order Department OP-154, American Medical Association, P.O. Box 10946, Chicago, IL 60610. Price: 50 or more sets, $1.50 per set; 5 to 49 sets, $3.50/set. AMA members receive a 10% discount.

Attorneys for the AMA and the American Hospital Association told the U.S. Supreme Court that lower court decisions blocking enforcement of federal "Baby Doe" regulations should be upheld. The case involves a 1984 federal law permitting the government to intervene in medical treatment decisions of seriously ill handicapped newborns. If implemented, the law would give federal investigators the right to enter hospital nurseries to demand inspection of the medical records of newborns.

Plans for the MSMA 118th Annual Session are progressing on scheduled. Members are encouraged to mark calendars now and make plans to attend, June 4-8, at the Royal d'Iberville Hotel in Biloxi.

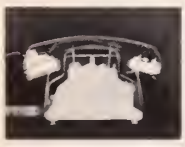
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DATELINE

Domestic Animal Rabies In Rankin County

Jackson, MS - A case of rabies has been diagnosed in a domestic dog in rural Rankin County. It is the first case of dog rabies in Mississippi since 1961, and the first in any land animals in more than 20 years. Although the case appears to be an isolated one, the State Department of Health notes that the presence of domestic animal rabies in the area means that many persons who sustain bites may need anti-rabies prophylaxis. For information, call 354-6660.

UMC Schedules Renal Update, Surgical Forum

Jackson, MS - University Medical Center will present its annual Renal Update and the XIII Annual Postgraduate Surgical Forum early next month. Renal Update is scheduled for March 6-7 at the Ramada Renaissance, and the Surgical Forum, March 13-15 at the Holiday Inn Downtown in Jackson. For more information, contact the University Medical Center Division of Continuing Health Professional Education, 984-1300.

Medicare Participation Required for Licensure

Chicago, IL - Trial of a lawsuit seeking to prevent Massachusetts from implementing its new law requiring Medicare participation as a condition for physician licensure was delayed after the state assured medical groups that it would not start implementing the law until at least 1987. The AMA has joined the Massachusetts Medical Society and individual physicians in requesting a permanent order enjoining the law's implementation.

Progress in Relative Value Scale Development

Chicago, IL - Harvard University has agreed to the final terms of a cooperative agreement with the Health Care Financing Administration (HCFA) for conducting a study aimed at developing a new relative value scale which would provide the basis for changes in the way Medicare pays physicians. The way now has been cleared for the AMA to complete arrangements on its role as a subcontractor with Harvard.

Gamma Globulin Helps Children with AIDS

Chicago, IL - Preliminary studies from the Albert Einstein College of Medicine in New York show that periodic intravenous gamma globulin treatments restored suppressor T cells to the normal range and prevented almost all bacterial infections in some children with AIDS or AIDS-related complex. The report is published in the February issue of the American Journal of Diseases of Children.

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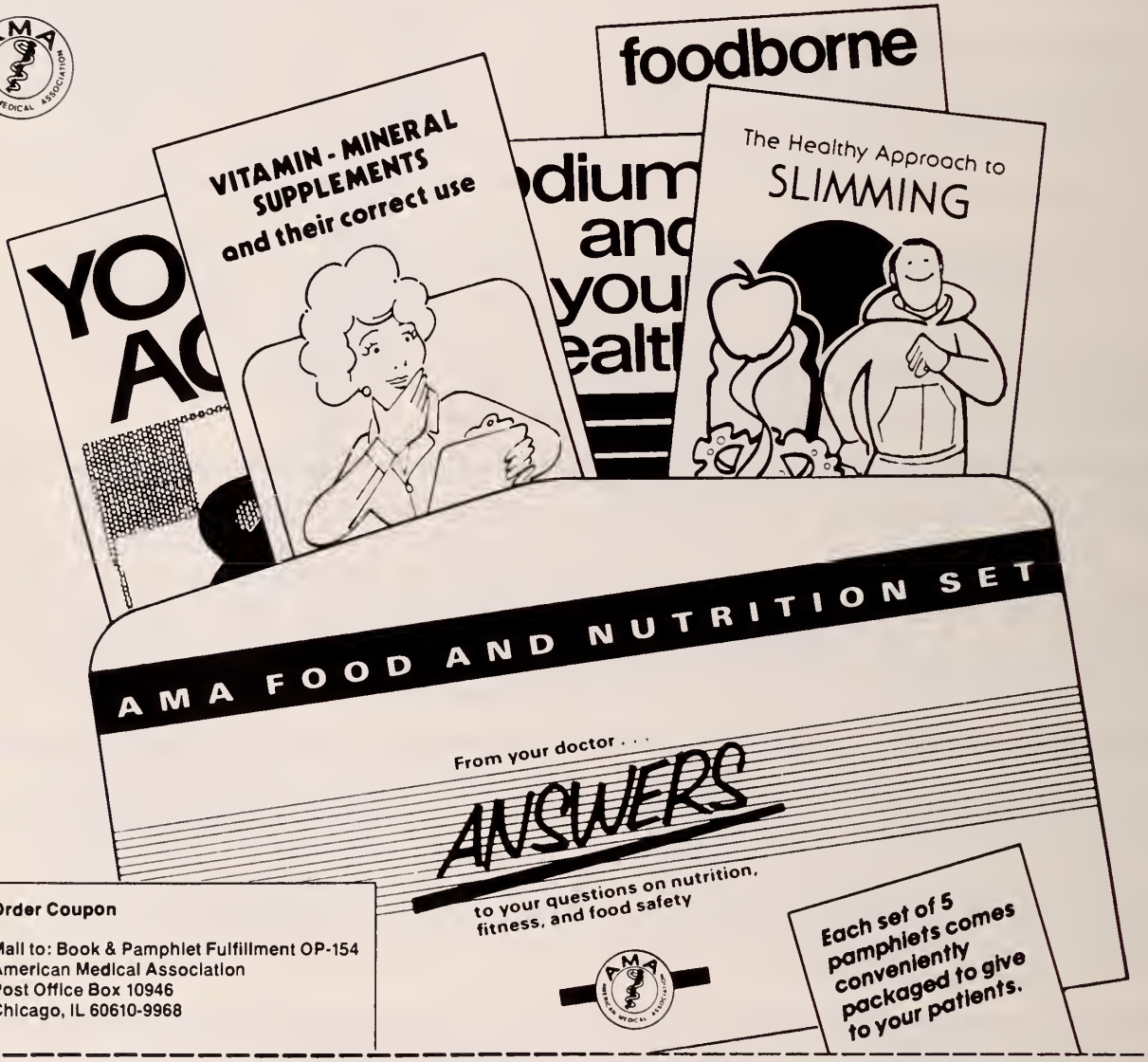
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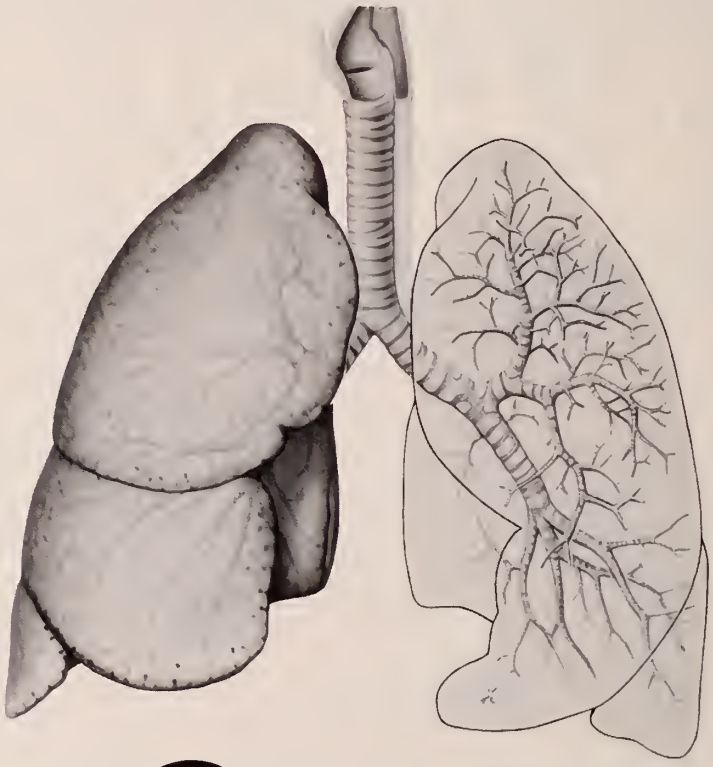
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Brief Summary Consult the package literature for prescribing information

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae* and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — *Pregnancy Category B* — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.16, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[0617B2R]

Note: Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: **Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired.** If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of Dyrenium (triamterene, SK&F CO.) and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

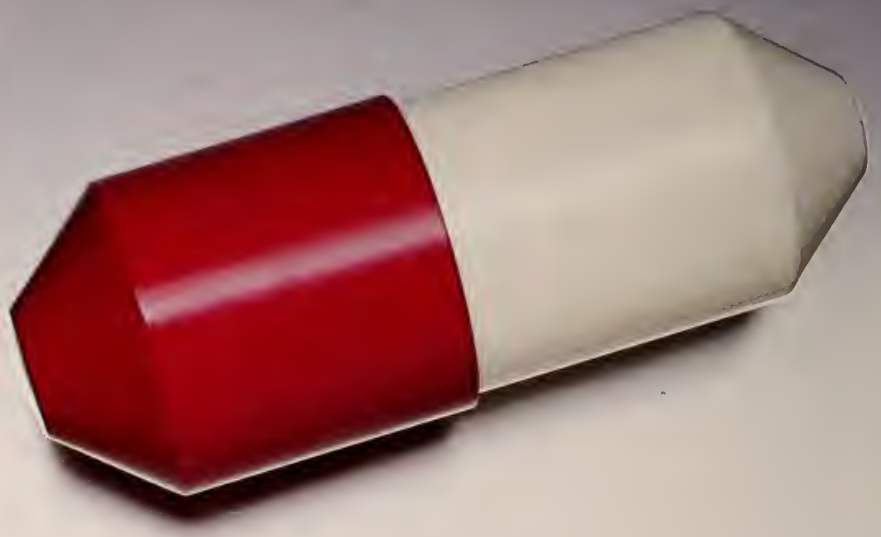
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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
February 1986, XXVII, Number 2

ORIGINAL PAPERS

Cat Scratch Encephalopathy

ANNA WRIGHT, JOHN MOFFITT, M.D., and OWEN B. EVANS, M.D.
Jackson, Mississippi

Uncomplicated cat scratch is a mild illness of children and young adults. Encephalopathy is an unusual but serious complication of cat scratch disease. The neurologic manifestations can be quite profound, but the outlook is generally good. The clinical courses of three recent cases of cat scratch encephalopathy are presented, and the clinical features, diagnosis, management, and prognosis of cat scratch encephalopathy are briefly discussed. This diagnosis should be considered in cases of encephalopathy associated with regional lymphadenitis.

Cat Scratch Disease (CSD) is typically a mild illness characterized by malaise, low grade fever, anorexia, headaches, and localized unilateral lymphadenitis that follows a cat scratch or a bite.[1] The disease occurs primarily in children and adults after an incubation period ranging from 3 to 30 days. Up to 14% of patients have unusual manifestations of CSD including Parinaud's oculoglandular syndrome, osteolytic lesions, erythema nodosum, and thrombocytopenic purpura. Neurologic manifestations are uncommon but are the most serious.[2] CSD with associated encephalopathy was first reported in 1952 by Stevens,[3] and only a few cases have been subsequently reported in the English literature.[2-8] We describe three additional cases of CSD encephalopathy in this report.

Case Reports

Case 1. A 10-year-old male was in good health until three weeks prior to admission when he developed fever and abdominal pain. He was treated for six days with an antibiotic for presumed otitis media. During this time the child was scratched on his right arm by the family cat with subsequent swelling and tenderness at the site of the scratch. He continued to be febrile, primarily at night. One week prior to admission a large right axillary mass was noted, and a presumptive diagnosis of CSD was made.

From the Department of Pediatrics, University Medical Center, Jackson, MS.

One day prior to admission the patient lost consciousness for several minutes without apparent motor activity or incontinence, and then became irritable, disoriented and lethargic. He was hospitalized for observation and showed no improvement over the subsequent two days. The patient was transferred to the University of Mississippi Medical Center Children's Hospital for further evaluation. There was no prior history of trauma, nausea, vomiting, or headache.

On physical examination the patient appeared lethargic, irritable, and intermittently disoriented. Vital signs were normal except for temperature of 100.9°F. Shotty inguinal nodes were present but there was no other adenopathy, scratches or skin lesions. The remainder of the physical examination

was unremarkable. There were no cranial nerve, cerebellar, motor or sensory abnormalities. Deep tendon reflexes were depressed but symmetric. There was no Babinski sign or meningismus.

Initial laboratory evaluation showed a normal complete blood count (CBC) and differential, urinalysis, chest radiograph, and blood chemistries. A lumbar puncture revealed clear cerebrospinal fluid (CSF) with an opening pressure of 240 mm of water. Cell count revealed 7 cells with predominance of lymphocytes. The CSF glucose was 22 mg/dl and the protein was 59 mg/dl. Bacteriologic smears and cultures were negative as were the CSF VDRL and cryptococcal antigen. A PPD skin test was nonreactive at 48 hours and blood and urine toxicology screens and heavy metal screens were normal.

The hospital course was one of rapid improvement. The day following admission the patient was more cooperative and alert without irritability. He continued to have slight nocturnal fever during hospitalization and complained of mild pain in his right jaw. There was daily improvement, and after five days his mental status and neurologic examination had returned to normal. A cat scratch antigen skin test was applied one week after discharge and was positive within 24 hours.

Case 2. A 7-year-old male was in good health until three weeks prior to admission when swelling in his right axilla was noted. The axillary mass enlarged initially but soon decreased in size with no associated symptoms. The day prior to admission the patient was restless and had difficulty with sleep. On the morning of admission the patient appeared normal and was sent to school. While at school he had a generalized motor convulsion, and while en route to a nearby hospital he had four additional convulsions. Following this he was combative, disoriented, and responsive only to noxious stimuli. He was treated with intravenous phenytoin which controlled the seizures. A lumbar puncture showed two lymphocytes with CSF glucose of 63 mg/dl and a protein of 19 mg/dl. The patient was transferred to the University Medical Center for further evaluation. Review of systems was significant only for a previous episode of lymphadenopathy associated with a presumed viral illness approximately one year prior to admission and congenital ptosis of the left eye. There was no history of recent exposures other than to the numerous cats in the home. Immunizations were up to date. There was a family history of seizures.

On physical examination the child appeared healthy with normal vital signs. A small nonpurulent skin laceration was present on the right distal forearm, and a 1.5 × 1.5 cm firm, movable right axillary mass was palpated. No other adenopathy or meningismus was noted and the remainder of the general physical examination was normal. The neurologic examination revealed a intermittent disconjugant gaze and a left ptosis. The fundi were normal. The deep tendon reflexes were depressed but were symmetric. There was no Babinski sign. Motor strength and tone were normal and there were no sensory deficits. The patient was disoriented and combative and required restraining devices.

Initial laboratory evaluation showed a normal CBC and differential, urinalysis, and chest radiograph. Blood chemistries were within the normal limits, and a blood and urine screen for toxins and heavy metals was normal. A lumbar puncture showed clear CSF with opening pressure 350 mm water. There were 13 cells in the CSF with 95% lymphocytes. The CSF glucose was 53 mg/dl and the protein 23 mg/dl. No organisms were seen on bacteriologic stains and subsequent cultures were normal. A cat scratch antigen skin test was applied and was positive within 24 hours.

On the morning following admission, the patient had resolution of most of his neurologic signs and symptoms. The following day he had returned to his usual behavior, and was discharged. Follow up examination one week later revealed a normal neurologic examination and electroencephalogram (EEG).

Case 3. This 6-year-old female had been followed for three years for a generalized motor seizure disorder treated with Primidone 250 mg b.i.d. One week prior to her next clinic evaluation, the parents noticed a swelling in the left axilla simultaneous with the onset of a low grade fever of 100-101°F. Two days prior the patient became sleepy and irritable, and complained of a headache. On the following day, she was kept home from school with a fever of 104°F. That evening she became confused, lethargic, and began having hallucinations. Through the night her symptoms improved and the child was brought for her scheduled appointment. There had been no recent illnesses or injuries. There were numerous cats in the house, and there was a history of numerous scratches. No other family members were ill.

On examination the child had a slightly tender 3 × 3 cm mass in the left axilla. There were numerous excorations on both hands, and a temperature of 100°F. The remainder of the examination was normal. On neurologic exam, the patient was lethargic

but oriented and cooperative. There was minimal meningismus, and the fundi were normal. Cranial nerves, reflexes, muscle strength, coordination, and sensation were normal. Serum Primidone level was 6 ug/ml and serum phenobarbital was 12 ug/ml.

The patient returned the following week for re-evaluation at which time all neurologic signs and symptoms had resolved. A cat scratch antigen was applied and was positive at 48 hours.

Discussion

The most commonly reported neurologic complication of CSD is encephalopathy, although myelitis and radiculitis have also been reported.[6] The encephalopathy may occur when other signs and symptoms of the disease have resolved. The neurologic symptoms usually develop within six weeks following the onset of the adenopathy, and the clinical presentation is very similar to the cases reported here: abrupt onset of confusional behavior, seizures, and altered mental status. The neurologic findings during the acute stage include: either hyper- or hyporeflexia, nuchal rigidity, extensor plantar responses, muscle weakness, altered mental status, decerebrate posturing, and occasionally optic neuritis. Symptoms usually resolve within 2 to 10 days although recovery may require up to several months.[7] A complete recovery can be anticipated. There are no confirmatory laboratory tests. The CSF may show mild pleocytosis; however, it is usually normal.[4] The EEG is usually abnormal showing diffuse slowing but there are no specific abnormalities suggestive of the disease.[5]

The etiology of CSD was previously thought to be viral in origin. Recently, however, small pleomorphic gram negative bacilli have been isolated from affected lymph nodes of patients with CSD.[9, 10] There have been reports of epidemics of cat scratch disease both in families as well as communities. The disease is more common in the winter and fall.[1] The mechanism of the central nervous system involvement is unknown but may be similar to post-vaccinal encephalopathies.

The diagnosis of CSD with encephalopathy depends on the following criteria:[6] (1) history of a cat scratch or contact with a cat; (2) regional adenopathy; (3) positive skin test with cat scratch antigen; (4) histologic evidence from biopsied lymph node consistent with CSD; (5) otherwise unexplained encephalopathic disease developing within six weeks of an appearance of adenopathy. The strongest evidence for making the diagnosis is a positive skin test,[2] and in many cases with a positive skin test, a clinical diagnosis can be made without a biopsy.[9] The skin test antigen is prepared from aspirated material collected from affected lymph nodes of persons with CSD. One-tenth ml of the antigen is injected intradermally and a positive reaction is defined as a 5 mm or greater area of induration with or without erythema within 72 hours. Ninety-four percent of patients who have a clinical picture of CSD will have a positive skin test with false positive occurring in 4% to 8%.[2] To avoid false negative results, the skin test should not be done earlier than one week after the onset of the adenitis.[5] The treatment of CSD with encephalopathy is supportive. There is no evidence to support the use of antibiotics or steroids at this time. Anticonvulsants are indicated for seizure control.[1]

In cases of a rapidly progressive encephalopathy developing after an episode of regional lymphadenitis with or without a history of a cat scratch, the diagnosis of CSD should be considered. ★★★

Acknowledgement

The authors thank Drs. Peggy Wells, Clarksdale, and Sam Suttle, Louisville, for referring the patients and Dr. Peter Wright, Vanderbilt University, Nashville, for supplying the cat-scratch antigen.

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A Case In Point For Early Intervention: MENINGOCOCCEMIA

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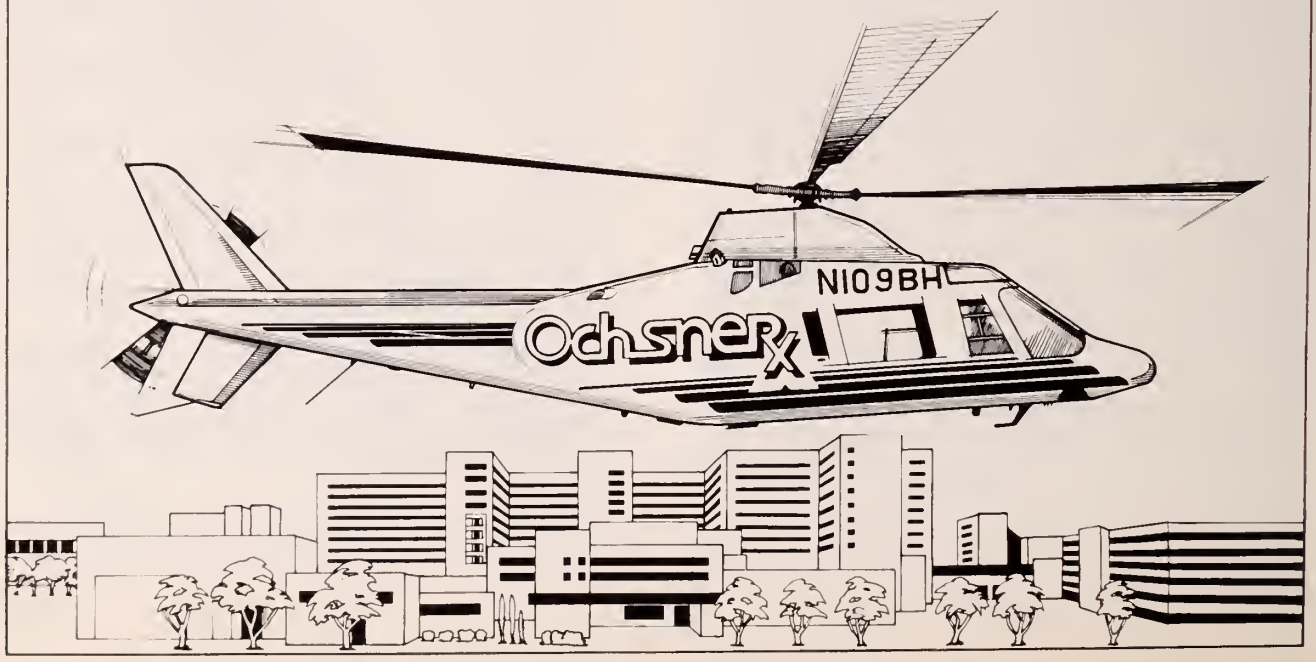
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The child did develop severe ARDS for which conventional and high frequency ventilation were used. Because of further pulmonary problems, *extracorporal membrane oxygenation* was begun and this was successful. The patient was discharged home with his family, to be followed by his family physician.

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New Orleans, LA 70121



Adverse Drug Reaction Reporting by Mississippi Physicians

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It has been estimated that adverse drug reactions (ADRs) cause approximately 30,000 deaths and 1.5 million hospital admissions annually. In response to this national problem the Food and Drug Administration has maintained a reporting system for ADR's. In this article the authors examine the role of the reporting system and some of the reasons physicians do not participate. Findings from various studies, including a survey of Mississippi primary care physicians, are discussed.

According to Martin, the harmful or adverse effects of prescription medications "have exacted a staggering toll in needless suffering, time-consuming litigation, economic loss and destruction of human life."[1] The precise magnitude of the adverse drug reactions (ADR) problem can be only roughly estimated. Smith and Knapp have stated that 10 percent is frequently cited as the incidence of unwanted effects to drugs.[2] However, this estimate disguises the variability of the incidence of ADR's in the literature. In a review of adverse drug reactions reports, Martin found the incidence of ADRs to range widely from a fraction of one to 30 percent, depending on the drug, the treatment setting and other therapeutic variables.[1] It has been estimated that ADRs cause approximately 30,000 deaths and 1.5 million hospital admissions annually at a cost of $3 billion.[3, 4]

In response to this national problem the Food and Drug Administration has maintained a reporting system for ADRs since the mid-1960's which has logged over 230,000 reports. Approximately 90 percent of the reports received are from manufacturers while 10 percent are direct reports from health and medical care providers. In recent years the annual number of reports has increased from 10,000 to 40,000 primarily as a result of increased reporting by pharmaceutical manufacturers. A portion of the increase has been accounted for by foreign reports and by reporting results of postmarketing surveillance studies.

ADR reporting is complex because of the large numbers of products and types of adverse reactions involved. There are approximately 20,000 prescription drugs on the market; about 150 new products enter the market each year. Adverse reactions range from trivial to life-threatening and include known and expected reactions. For an adverse reaction to be reported it must be detected, attributed to the drug and then reported.

Limitations of Clinical Trials

Pre-marketing drug studies, or clinical trials, have become well established and accepted as the basis for release of efficacious drugs at the earliest reasonable time. However, clinical trials have five major inherent limitations in detecting ADRs:

1) Size — usually no more than 3000-5000 patients are studied;
2) Duration — usually trials are no longer than 3-5 years, and possibly less;
3) Scope
   a) many types of patients who will ultimately use the drug are excluded from the studies (e.g. pregnant women, children, the elderly, etc.)
   b) studies are often limited to specialists affiliated with large medical centers (excluding the average physician engaged in clinical practice); and
4) Narrow drug indications are studied; other in-

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dications may arise after approval and marketing.[5]

Therefore, a portion of the drug's evaluation must occur subsequent to marketing until its effects have been adequately documented. Consequently, rare side effects, even when serious, may go undetected until the drug is used in a heterogeneous population of physicians and patients under "naturalistic" conditions.

Role of ADR System

The role of the ADR system is to detect early warning signals which often require further detailed testing by more formal epidemiologic studies. The central importance of a physician spontaneous ADR reporting system is that it is the only cost-effective means to detect rare events associated with drugs in actual practice. As mentioned, approximately 36,000 reports are received by the FDA annually from manufacturers and only 4000 directly from medical care providers. According to the FDA, proportionately, care providers report more serious and unexpected reactions than manufacturers. Consequently, direct reports are an important source of signals to the detection system.

The reporting dynamics for adverse reactions are largely unstudied and little is known about what motivates a physician to report or not report an ADR. Awareness of the system, access to reporting forms and the reporting form itself are probably important. Jones has stated that lack of sufficient feedback from the FDA and fear of medical-legal problems constitute major inhibitions for ADR reports.[6] In a review of adverse drug reaction reporting in the United Kingdom,[7] Inman described the "seven deadly sins" which result in non-reporting to be:

1) *Complacency*, the mistaken belief that only safe drugs are allowed on the market.
2) *Fear* of involvement in litigation, a lesser problem perhaps in the United Kingdom than in the USA.
3) *Guilt* because harm to the patient has been caused by the treatment the doctor has prescribed.
4) *Ambition* to collect and publish a personal series of cases, a common human failing that may lead to serious delays in recognition of a hazard.
5) *Ignorance* of the requirements for reporting, perhaps as a result of failure in communication between the reporting centre and the professions.
6) *Diffidence* about reporting mere suspicions which might perhaps lead to ridicule.
7) And finally, *lethargy* — an amalgam of procrastination, lack of interest or "time," inability to find a report-card and other excuses.

It is clear that a better understanding is necessary of issues and attitudes which influence the physician's decision whether to report an ADR.

Recently the Health Services Research Division of the Research Institute of Pharmaceutical Sciences at the University of Mississippi conducted a survey of primary care physicians in Mississippi. As part of the survey physicians were asked several questions concerning their adverse drug reaction experiences during the preceding year. As shown in Table 1, 85.5 percent of the 262 physicians responding had observed one or more ADRs in their practice. Sixty percent of the physicians estimated that they had encountered ten or more ADRs during the past twelve months. Of the estimated 8333 ADRs observed by the responding physicians 82.4 percent were judged by the physicians to be severe enough to necessitate a discontinuation or change in therapy.

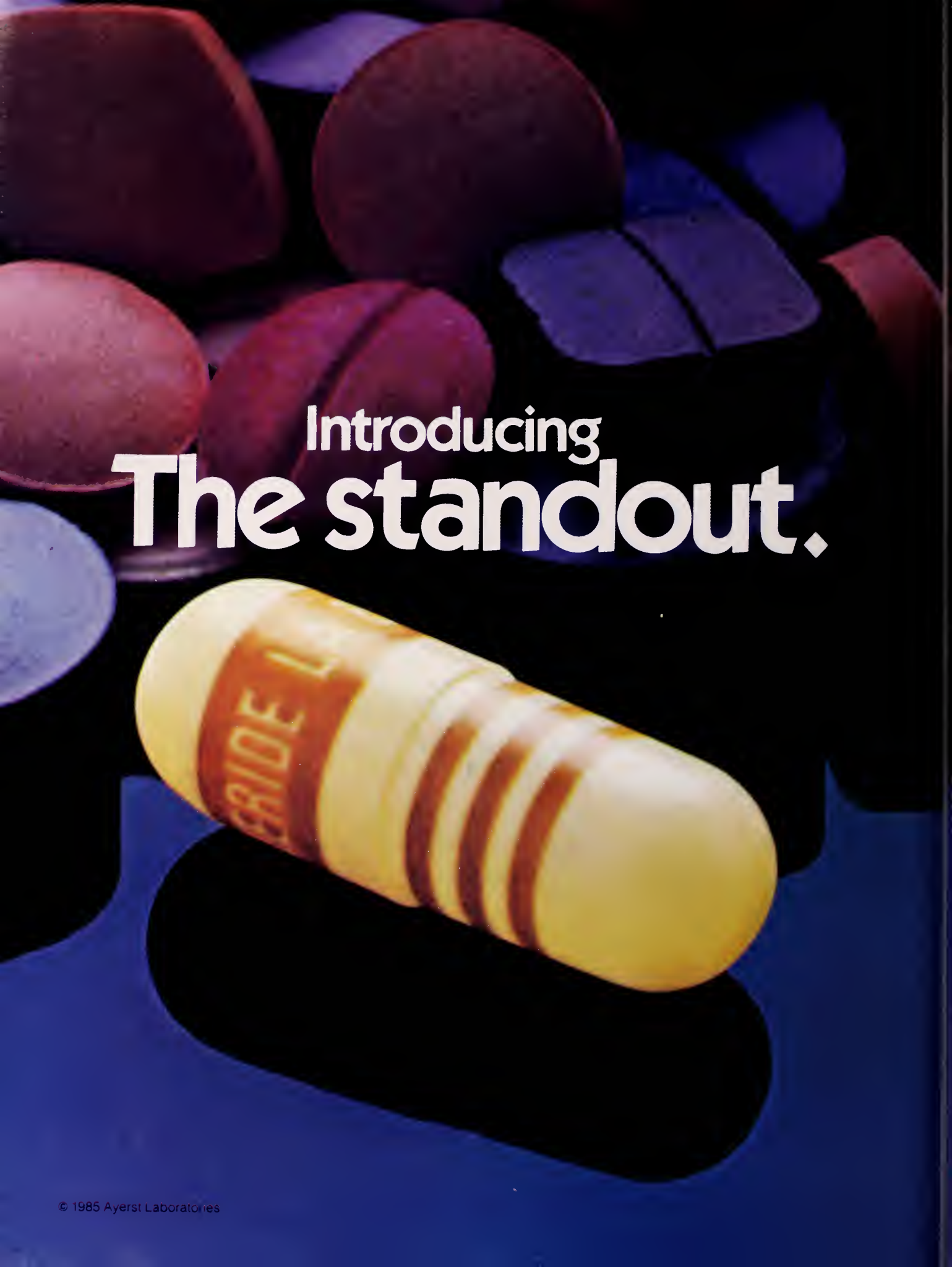
In addition to the frequency of occurrence, physicians were then asked about the frequency of reporting ADRs to drug manufacturers and the FDA. Of those responding, 18.7 percent indicated they had reported one or more ADR to a drug manufacturer and 5.7 percent responded they had reported ADRs to the FDA. These reports accounted for only 1.9 percent and 0.3 percent, respectively, of the more than 8000 ADRs observed. The overall reporting rate of ADRs to either the FDA or a drug manufacturer, then, was only 2.2 percent. This figure is consistent with other studies which estimate that only 1 percent to 10 percent of adverse reactions are actually reported.[1, 8]

In an attempt to identify motivating or inhibiting factors in the ADR reporting process, physicians were asked to indicate reasons why they would and would not report ADRs. The most frequently cited (74.4%) reason that the physicians *would* report an ADR was that the observed reaction is not currently described in the package insert (see Table 2). Concerns about the quality of health care products and a sense of professional duty were each indicated as motivating factors to report ADRs by 48.1 percent of the responding physicians. Thirty-seven percent of physicians indicated that legal liability concerns would motivate them to report an ADR, and 18 percent of physicians stated that they would report an ADR if it was serious enough to necessitate a change in therapy.

The most frequently indicated reasons that physicians would *not* report an ADR were that the adverse reaction was not of a serious nature (76.3%)



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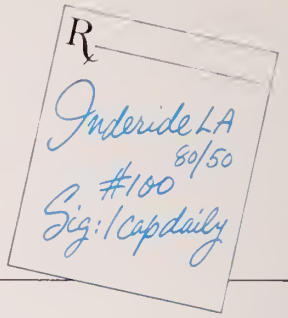
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Propranolol hydrochloride (INDERAL®):
Propranolol is contraindicated in: 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol.

Hydrochlorothiazide:
Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS

Propranolol hydrochloride (INDERAL®):
CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated, and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or propranolol should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of propranolol therapy. Therefore, when discontinuance of propranolol is planned, the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patients should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide:
Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS

Propranolol hydrochloride (INDERAL®):
GENERAL. Propranolol should be used with caution in patients with impaired hepatic or renal function. Propranolol is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that propranolol may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs, such as reserpine, should be closely observed if propranolol is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies, in both rats and mice employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY. Pregnancy Category C. Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose. There are no adequate and well-controlled studies in pregnant women. Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS. Propranolol is excreted in human milk. Caution should be exercised when propranolol is administered to a nursing mother.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

Hydrochlorothiazide:
GENERAL. Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely: hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are: Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect of digitalis (eg, increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content.

Any chloride deficit is generally mild and usually does not require specific treatment, except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism, such as renal lithiasis, bone resorption, and peptic ulceration have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

DRUG INTERACTIONS. Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

PREGNANCY. Pregnancy Category C. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnancy requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

NURSING MOTHERS. Thiazides appear in human milk. If use of the drug is deemed essential, the patient should stop nursing.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL®):
Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

Hydrochlorothiazide:
Gastrointestinal: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis.

Central Nervous System: Dizziness, vertigo, paresthesias, headache, xanthopsia.

Hematologic: Leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

Cardiovascular: Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity: Purpura, photosensitivity, rash, urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis), fever, respiratory distress, including pneumonitis, anaphylactic reactions.

Other: Hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

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TABLE 1
PREVALENCE, SEVERITY AND REPORTING OF ADVERSE DRUG REACTIONS

Number of ADRs seen in practice during last year	0	38 (14.5%)
	1-15	122 (46.6%)
	16-30	49 (18.7%)
	31-99	29 (11.1%)
	100+	24 (9.2%)
	Mean (50)	27.8
Percent of ADRs during last year which were serious enough to necessitate a change in therapy	0%	47 (17.9%)
	1-25%	27 (10.3%)
	26-50%	45 (17.2%)
	51-75%	33 (12.6%)
	76-100%	110 (42.0%)
	Mean (50)	58.2
During last year, number of ADRs reported to:		
Drug Manufacturer	0	213 (81%)
	1	23 8.8%)
	2	9 (3.4%)
	3	3 (1.1%)
	4+	14 (5.4%)
	Mean (50)	0.6
Food and Drug Administration	0	247 (94.3%)
	1	11 (4.2%)
	2	2 (0.8%)
	3	0 (0.0%)
	4+	2 (0.8%)
	Mean (50)	0.1

TABLE 2
REASONS PHYSICIANS *WOULD* REPORT ADVERSE DRUG REACTION

	Percent Indicating Reason; N = 262
Observed reaction is not currently described in package insert	195 (74.4%)
Concerns about quality of health care products	126 (48.1%)
Ethical/professional duty to report such cases	126 (48.1%)
Legal liability	97 (37.0%)
Enjoy contributing to medical knowledge base	70 (26.7%)
Reaction is serious enough to necessitate a change in therapy	47 (17.9%)

TABLE 3
REASONS PHYSICIANS *DO NOT* REPORT AN ADVERSE DRUG REACTION

	Percent Indicating Reason; N = 262
Adverse reaction was not of a serious nature	200 (76.3%)
Observed reaction was an anticipated or established side effect of the drug	198 (75.6%)
It is often difficult to establish cause and effect for a given reaction	140 (53.4%)
Don't have the time to fill out formal reports	59 (22.5%)
Reporting procedure is too complex	46 (17.6%)
Have never received feedback or follow-up from reports submitted	23 (8.8%)
Legal liability concerns	14 (5.3%)

and the observed reaction was an anticipated or established side effect of the drug (75.6%) (see Table 3). Over fifty percent of physicians indicated that they would not report an observed ADR because it is often difficult to establish a cause-and-effect relationship between a particular drug and an undesirable effect. Only 17.6 percent of the physicians indicated that the reporting procedure was too complex, and 22.5 percent stated they did not have enough time to fill out the formal reporting forms. Issues of lack of feedback concerning their ADR reports and legal liability were inhibiting factors for only 8.8 percent and 5.3 percent, respectively, of physicians.

Discussion

Most of the results from this exploratory survey conducted by the Research Institute of Pharmaceutical Sciences are consistent with those from other studies of ADR reporting; however, several interesting inconsistencies emerged as well. Unfortunately, the low rate of ADR reporting suggested in the literature, indeed, the lower end of the range, was supported by the physician responses to this survey. Furthermore, the estimated 185 ADRs which were reported either directly to the FDA or to a manufacturer represent, at best, only 2.7 percent of those reactions which were judged severe enough to necessitate a change in therapy. It is interesting to note that the proportion of physicians who indicated that they *would report* an observed ADR if it was serious enough to necessitate a change in therapy was generally consistent with the proportion of physicians in the survey who actually reported one or more ADRs. However, the inconsistency lies in the fact these physicians reported only a small percentage of the severe reactions occurring in their practices. If the 18 percent of the physicians who indicated that they *would* report an ADR which was serious enough to necessitate change in therapy actually did so for all of the serious ADRs indicated by them, more than 1200 ADRs would have been

reported. Confounding this inconsistency between attitude and action further are the large proportions (nearly 50%) of physicians who indicated they would report an ADR out of professional duty and concern for quality in health care products.

It is also interesting that the reasons for *not* reporting commonly suggested in the literature were not supported by physicians in this survey. Frequently cited issues of lack of feedback and legal liability were of only minor concern to this sample of physicians. The complexity of forms and the length of time necessary to complete formal reports were somewhat more important; however, the most important reasons for not reporting were of a clinical rather than mechanical nature. Physicians indicated that it was not necessary to report reactions which were not serious or which were already established side effects of the drug. A majority of physicians also indicated that they would not report an ADR without establishing, with reasonable certainty, a cause-and-effect relationship between a drug and given effect.

Summary

A large proportion of the physicians responding to this survey indicated that reporting adverse drug reactions to a drug manufacturer or the FDA is a good and worthwhile thing to do. However, the substantial under-reporting of serious ADRs by these physicians indicates a lack of motivation, the existence of major inhibitions or a combination of these.

The decision to report or not report appears to be driven by the notion that an observed undesirable therapeutic effect can be classified in one of three ways: (1) the event is an established side-effect mentioned in the package insert; therefore, it is not necessary to report it; (2) the effect is not of a serious nature; therefore, it is not necessary to report it; (3) the effect has not been described previously in the drug information literature; therefore, it should be reported. This decision-to-report criterion is tempered, however, by the condition that a reasonably certain causal relationship between the drug and effect can be established by the physician.

The problem with this decision-making process is that it employs only the extremes, anticipated vs. unexpected effects, and ignores the middle or gray areas of what is actually a continuum of drug use experience. This results in a "Catch-22" situation which can severely impede the necessary development and dissemination of an accurate drug effect profile. Physicians largely depend on information contained in the package inserts and the most commonly used desk-top reference books. These information sources are based primarily on data obtained from pre-marketing clinical trials. Prevalence rates for the various side effects, where given, only apply to the small cohort of test subjects. Approximation of the true prevalence of adverse effects can only be documented after a drug is released and monitored in general use. Therefore, physicians who refrain from reporting observed side-effects because they are "not serious" or are "established" in the package insert are helping to retard the growth of drug effect profiles by not adding this information to the data base. Similarly, physicians who hesitate to report unanticipated or "non-established" suspicious events because they are uncertain about the causal relationship between a drug and an effect, are depriving the drug evaluation system of potentially vital information which is used in producing the "established effects" described in the package insert. If this new and additional information does not get into the drug effect profile, a virtually closed system results with little information going in or coming out of the file.

This may be an oversimplified description of a very complex process, but it demonstrates the importance of each physician's awareness of his/her role in adverse drug reaction detection and reporting. Recognizing an ADR can be one of the most difficult diagnoses a physician has to make. However, as Rossi et al assert, an effective spontaneous reporting system depends solely on the active participation of astute and conscientious physicians and others in reporting their suspicions to the medical literature, the FDA or the drug manufacturers.[9] While the mechanics of the present reporting system may present problems which inhibit physicians from getting involved, these problems cannot be satisfactorily resolved without user input. This survey has reported the attitudes of only a small proportion of the practitioners in the state. The results demonstrate a need for further, in-depth investigation of the ADR reporting system. The authors encourage each physician to reflect seriously on their own ADR reporting activities to identify the reasons why they report or do not report ADRs and to share their attitudes with the FDA. ★★★

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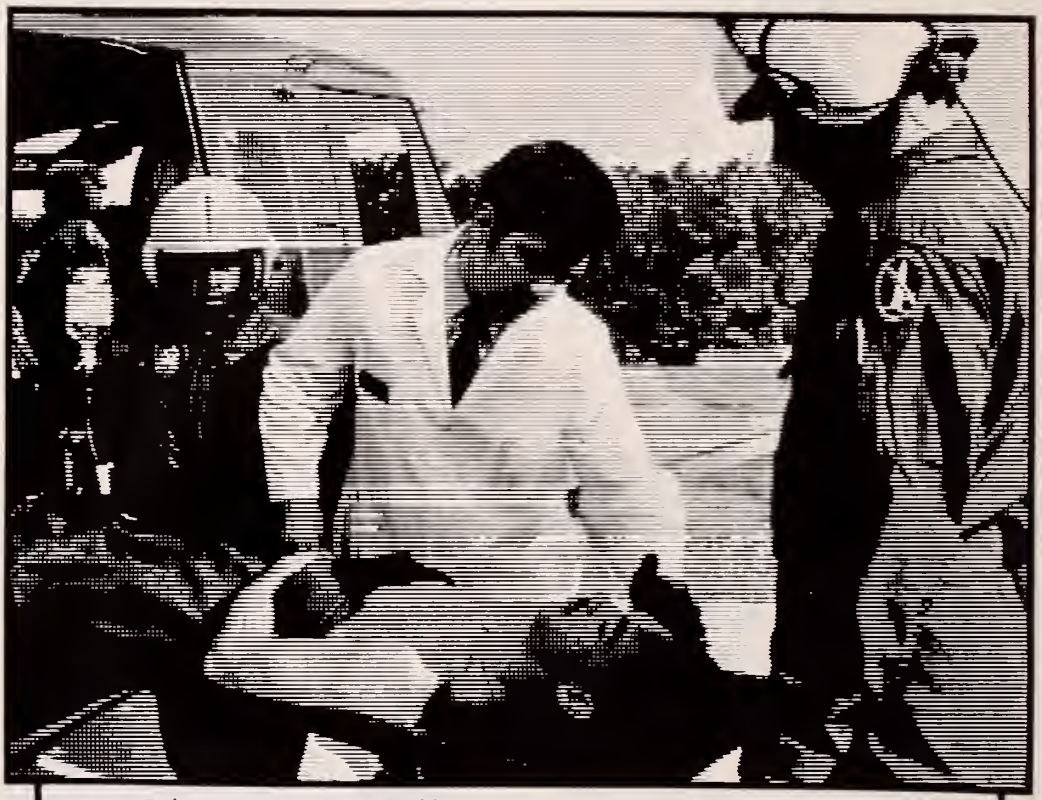
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Obstetrics and Gynecology Grand Rounds
Clinical Case Management XI:

Management of Ectopic Pregnancy

BRYAN D. COWAN, M.D., Moderator
G. RODNEY MEEKS, M.D., Series Coordinator
Jackson, Mississippi

DR. COWAN: CR is a 24-year-old, nulliparous white woman who had 3-4 years of unprotected intercourse without conception. Her husband is 30 years old and in good health. He had fathered two children previously. She denied any sexually transmitted disease but gave a vague history of abdominal pain, which required five days of hospitalization and parenteral antibiotics. She had had no prior infertility evaluation. Her menarche occurred at age 11 and menses occurred irregularly, 30-60 days apart. Flow lasted 1-7 days. She had occasional mild dysmenorrhea. She had no significant dyspareunia. Review of systems, family history and social history were unremarkable. Her general physical examination was physiologic and pelvic examination was normal. What evaluation would you initiate?

DR. MCMILLAN: This episode of pain may well have been pelvic inflammatory disease (PID). Therefore, tubal factor has to be of prime importance. I would perform a hysterosalpingogram (HSG) in the first half of the cycle to evaluate the tubes. Irregular menses, occurring every 30-60 days, indicate an ovulatory problem. With enough ovarian damage from PID ovulation may not occur regularly. Also polycystic ovaries will result in irregular menses.

DR. COWAN: Would you begin ovulation induction before HSG?

DR. MCMILLAN: I would start clomiphene. She will not conceive unless she ovulates.

DR. COWAN: How do you use clomiphene?

DR. MCMILLAN: I begin with 50 mg a day for 5 days.

DR. COWAN: When should clomiphene be started?

From the Department of Obstetrics and Gynecology, University Medical Center, Jackson, MS.

Panelists: Ira L. Couey, M.D., Oxford, MS and Beverly A. McMillan, M.D., Jackson, MS.

DR. COUEY: I usually start on day 5 of the cycle, but I know some who recommend day 2.

DR. COWAN: How should ovulation be monitored?

DR. MCMILLAN: Basal body temperature and midluteal progesterone concentrations are my choices. I do not perform endometrial biopsies on a routine basis.

DR. COWAN: Is a male evaluation necessary before ovulation induction?

DR. COUEY: Since male factors are responsible for about 30% of infertility, I would request a semen analysis before starting clomiphene.

DR. MCMILLAN: I have difficulty getting husbands to obtain semen. It is easier, psychologically, for women to go to the doctor than for men. I get a postcoital test (PCT) at midcycle, which is a reasonable indirect sperm count. If I get two consecutive poor postcoital tests, I stop my evaluation until the husband is evaluated by a urologist.

DR. COWAN: What are the side effects of clomiphene?

DR. COUEY: The complications of multiple births (especially twins) has to be explained to the patient. She could develop hyperstimulated cystic ovaries but that is not common. Breast tenderness is common, as are hot flashes.

DR. COWAN: How frequently should patients be evaluated once they have initiated clomiphene citrate?

DR. COUEY: Before starting the next cycle of

clomiphene I perform a pelvic exam to rule out any obvious ovarian masses.

DR. COWAN: This patient was withdrawn on medroxyprogesterone (Provera). She began basal body temperature charts (BBT's) and began clomiphene citrate ovulation induction at 50 mgs daily starting on day 5 and continuing to day 9. She was instructed to return in five weeks, but failed to keep that appointment. She called on an emergency basis seven weeks after her last visit. She complained of acute lower abdominal pain that was greater on the right than on the left, right shoulder pain, vaginal bleeding and faintness. Physical examination revealed lower abdominal guarding, more prominent on the right without definite peritoneal signs. Bowel sounds were normal. Pelvic examination disclosed bleeding from the os with exquisite cervical and uterine tenderness. The adnexa could not be palpated because of the extreme tenderness. A culdocentesis produced 12 cc of free-flowing, non-clotting dark blood. What are risk factors for ectopic pregnancy?

DR. COUEY: Induction with clomiphene can give a higher instance of ectopic pregnancy. A more significant problem however is the history of pelvic infection. Women who have tubal damage from infection are at extremely high risk for ectopic pregnancies. Additionally, the patient who has had previous abdominal or pelvic surgery, abdominal or pelvic infection or has undergone corrective infertility surgery is at increased risk for ectopic pregnancy.

DR. COWAN: What signs and symptoms are common with ectopic pregnancy?

DR. MCMILLAN: Cervical tenderness is an important criteria. Blood at the cervical os, abdominal pain and light-headedness are really classic for a tubal pregnancy.

DR. COWAN: What diagnostic tests are helpful?

DR. MCMILLAN: Culdocentesis is diagnostic if it is positive. A sonogram may help but in someone with shoulder pain and the other symptoms, I believe the diagnosis is obvious.

DR. COWAN: Would you perform a culdocentesis in the office?

DR. MCMILLAN: Yes.

DR. COWAN: Would you obtain a pregnancy test?

DR. MCMILLAN: If I get blood on the culdocentesis, it is irrelevant whether the pregnancy test is positive or not. A serum pregnancy test might be helpful, but this patient has acute signs and symptoms. The serum pregnancy test is helpful in a situation when there may be some difficulty making the diagnosis.

DR. COUEY: Surprisingly, the urine pregnancy test is positive most of the time in our lab. The sonogram can be helpful, but it depends on the expertise of the radiologist. A gestational sac found in the adnexa at the time of the sonogram is diagnostic (see Figure 1). Absence of an intrauterine gestational sac and a serum beta-HCG subunit that is above 6,000 units are diagnostic of an ectopic pregnancy, also.

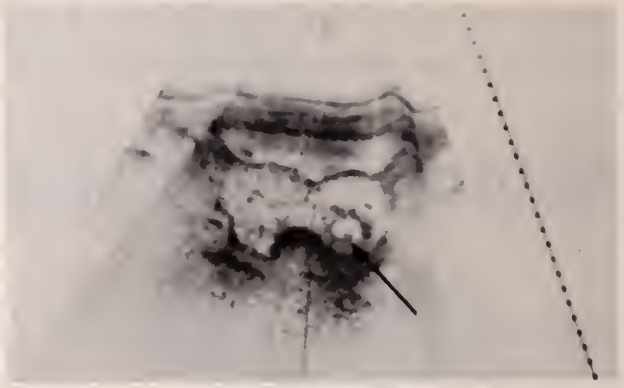


Figure 1. Transverse sonogram of the pelvis. A gestational sac with fetal pole (see arrow) is present in the adnexa. The empty uterus can be seen to the left and the bladder above the sac. (Courtesy Dr. John Y. Gibson, Department of Radiology, University of Mississippi Medical Center)

DR. COWAN: At laparotomy a right ruptured ampullary ectopic pregnancy was found. The left tube was clubbed. What kind of abdominal incision should be performed at laparotomy for an ectopic pregnancy, and should conservative tubal surgery be considered?

DR. COUEY: I almost always do a Pfannenstiel. I would do a salpingectomy with cornual resection. I have never performed any conservative tubal surgery.

DR. COWAN: Is there a place for reconstructive surgery or limited resection of the tube at the time of an ectopic pregnancy?

DR. MCMILLAN: Yes, as adoption becomes less of an option for infertile couples, I will be thinking about segmental resections.

DR. COUEY: If the bleeding can be controlled the tube could be saved. At a later date reconstructive surgery could be performed.

DR. COWAN: At the time of a salpingectomy for an ectopic pregnancy, would either of you consider removing the ovary on that side?

DR. COUEY: I would not take out the ovary.

DR. MCMILLAN: Neither would I.

DR. COWAN: If she had distal tubal disease on the contralateral side would you perform a tubo-

plasty and/or lysis of adhesions?

DR. MCMILLAN: I would perform lysis of adhesions but if it looked like she was going to require significant reconstructive work on the fimbriae, I would not do it then. I would re-operate in the future.

DR. COWAN: Suppose in the future she gets a second ectopic pregnancy and has a salpingectomy on that side because the tube is not salvagable. Would you consider a hysterectomy at the time of second ectopic?

DR. MCMILLAN: Prior to *in vitro* fertilization, removing the uterus which was a potential site of cancer was recommended by many. But with *in vitro* fertilization as a possibility, particularly in a young patient, I would not take her uterus out. This is something you talk with the patient about before you go to the operating room. She may give you some direction in what she wants.

DR. COWAN: For those of you who may wish to consider conservative surgery or limited surgery for ectopic pregnancy, I have seen an additional complication. The patient presented with an ectopic pregnancy which was removed and the tube was repaired. She presented two weeks later with a continuation of her ectopic pregnancy. This demonstrates how very important it is to remove all the trophoblast. Patients who undergo conservative tubal surgery for an ectopic pregnancy must be followed like patients with hydatidiform mole. Serial chorionic gonadotropin determinations are necessary to make sure they fall. They should fall to zero within a 10-14 day period. If they persist or rise, viable trophoblastic tissue is present, and a second opertation may be required to remove it. Another problem with reconstructive tubal surgery or conservative surgery is that only 10%-25% of the patients are able to become pregnant following surgery. To salvage the maximum reproductive potential of patients with ectopic gestation, tubal destruction from this process must be minimized. This includes early diagnosis using such adjuncts as ultrasound, beta-hCG surveillance, laparoscopy and recognition of risk factors for ectopic gestation. Once an ectopic pregnancy occurs, conservative tubal surgery should be considered. If salpingostomy or partial salpingectomy are not possible, certainly ovarian and uterine conservation should be the rule. Attempts at contralateral corrective surgery should be performed only under ideal circumstances.

DR. MEEKS: Ectopics are on the increase, and novel approaches are being attempted to preserve fertility. One reason for this is that so few babies are available for adoption. I would like to take the opportunity to thank Dr. Couey and Dr. McMillan for coming. It takes considerable time out from their busy practices. ★★★



The President Speaking

The Water's Fine

Ralph L. Brock, M.D.
McComb, Mississippi

If you had a daughter going on her first "real" date, which of the following situations would please you most?

1. Her date was a young man you had never met, he came to get her in his van, and they were going to a rock concert.

2. Her data was a young man you knew, had visited in your home several times, had his dad's car, and they were going to a function at a local church.

There is not much contest, is there?

To give you even more confidence and peace of mind, add the fact that you knew the boy's family, and they were going to your church where you were a member of the governing board.

In December you received a proposal suggesting that you and MSMA share two things some may value almost as much as a child — your medical practice and your money. You need to have just as much confidence in the MSMA and its leadership as you would your church in the situation mentioned above. The best way that I know to gain that confidence is to become active and participate in as many MSMA activities as possible.

Listed in the prospectus you received are four groups of names that you need to study carefully:

1. On page 11 is the list of persons presently serving on the MSMA Board of Trustees.

2. On page 12 and 13 are listed the members of the special committee that studied and recommended the formation of a statewide HMO/IPA.

3. On page 9-11 are the present directors of the Mississippi Physicians Practice Association (the IPA).

4. On pages 14-16 are the present directors of the Mississippi Physicians Health Insurance Company (the HMO).

These groups have wide geographical distribution and specialty representation. They also are the most knowledgeable concerning this project at the present time. I hope each of you know several of these physicians and feel comfortable in discussing this proposal with them.

Imagine, if you will, that the MSMA was given the opportunity to enter a parade with national reputation and importance. We studied the pro's and con's and observed closely other long-time and recent participants. We are on a side street watching the

(continued on page 43)

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XXVII, Number 2

FEBRUARY 1986

Airport — 1986

It was a rainy afternoon in late summer of 1935. I was visiting the Blasingames down the road from our house in Oxford where I was playing chauffeur for my sister's dolls when the news came over their Philco radio that Wiley Post and Will Rogers had been killed in an airplane accident. They had been my heroes and I could not believe that such a thing could have happened to them. It is equally hard to believe that it happened over fifty years ago.

Times change and heroes go by in a hurry nowadays. There seems to be an unending number of airplane crashes and airline emergencies. It makes you wonder how far we have really come in our "modern" age.

Thinking about airplane accidents reminds me that the airlines and the government through the FAA are finally getting the message — that passengers need and deserve better in-flight first aid and medical equipment. We also need some type of nationwide Good Samaritan legislation to cover those who participate in the in-flight emergencies.

If you've ever been around an emergency and found yourself without your medical bag or proper medical equipment . . . it is really frustrating. My first recollection of this was on the street at Times Square in NYC, when as a medical student I resuscitated a man with an acute myocardial infarction. The late Dr. Eva Linn Meloan had the same feelings when she managed to save a man's life on a flight from Ireland to New York.

The moral of this story is to hold on to your heroes; give your ole medical bag another loving squeeze; and pray for more and better in-flight equipment with proper legislation to cover us.

Thank God I am a physician.

Joe Johnston, M.D.
Associate Editor

THE PRESIDENT SPEAKING

(Continued from page 42)

parade go by. We have been told that we are the logical choice to represent Mississippi because we can go from Desoto to Jackson and Tishomingo to Wilkinson counties.

The Grand Marshal has just given us a deadline. There is an opening one block away, just behind Georgia, and we can have it if we can get ready. If we don't take it, there are several other groups in other side streets ready to take our place. If we miss this opportunity, we might as well pack our bags and go home.

None of us like having to get into the health insurance business, but if we can judge by what we read, hear, and see, the methods of delivering and paying for health care are making radical changes. Sooner than we would like to think, nearly everyone who walks up to our receptionists' desks will have some type of health card. This card calls for services from us agreed upon by previous agreement with the company. The method and amount of payment is also covered in the prior agreement with that company, and if we don't accept that card, the patient will go find a physician who does.

We have the opportunity of being one of these health care providers and most important of all, we can be the first in the entire state of Mississippi.

Let me reemphasize this to you: The changes are upon us, we can be an important part of the newest health delivery system, and we have the unique opportunity of getting the jump on the competition that is sure to come.

Turn your imagination on one last time and walk with me to the bank of an inviting but strange swimming hole. I am not asking you to jump in ahead of me and risk unknown dangers beneath the surface. I have gone in and, along with many others, have checked out all areas. I am now ready to call back to you: "Come on in, the water's fine."

★★★

COMMENT

Indigent Care — A View From the Countryside

In our egalitarian society government has a responsibility for the health of its people which can be fulfilled only by adequate health and social measures. In part to meet this obligation society has provided a helping hand to each of us to become physicians. No medical student or physician during his period of postgraduate training completely supports his own educational process. Public funds are utilized in the support of education either as direct subsidies or as part of grants from government, foundations, or voluntary agencies. Public monies fund the research that improves the state of the physician's art, helps to build the hospital where he works, and as often as not pays the fees of his patients. Health care has become more a matter of public interest and safety than a straightforward marketing of services. Even in today's entrepreneurial climate physicians will not be allowed to act with no regard for the effects of his actions on the society around him. The consumer's perceived right to health and life itself are no less strongly held than the perceived right of the physician to regulate his delivery of services. In this light we must remember that the state, through its licensure mechanism, grants certain privileges to physicians in the expectation that the medical needs of its people are met. Medical degrees are a privilege and not a right!

Medicaid with its imperfections is an effort by government to provide care to a large segment of its constituents. In our community, which is probably a microcosm across the state, physicians in certain specialties refuse virtually all primary Medicaid patients. For example, one primary care specialty and several surgical subspecialties do not see these patients.The burden falls on the patients and other physicians in the community who feel a societal responsibility. These physicians share an unfair load because their colleagues wish to be entrepreneurs seeking the patients with financial means. Medicaid patients are a responsibility of every licensed physician, and that medical care should be rendered in the local medical setting for these individuals if the physicians and support facilities are available to provide that care. In some settings where the Medicaid recipients are above a certain norm a quota system might be considered to assure "parity" among physicians. Certainly this is an explosive subject and approach; yet I prefer such self-imposed measures over options which nonmedical people or our legislators might provide.

The Medicaid program provides health care coverage for selected groups of low income individuals and families who happen to meet its arbitrary and confusing eligibility standards. In no way does it provide "for the poor." The indigent population includes the "uninsured poor" who have inadequate incomes, no private health insurance, and yet are ineligible for Medicaid. The responsibility for this population should be shared by physicians, hospitals, ancillary medical services (e.g. drug houses), county and local governments, and by the individual patient.

My suggestions are innovative not in new ideas but rather in a reaffirmation of older ones which are still valid. The outline for this proposal is as follows:

(1) *County and local governments*. Each governing body has a responsibility for its people. County hospitals through millage and Hill-Burton funds assumed this role over the state in earlier years. Today some of these hospitals are free-standing, tax-exempt institutions with no county or local millage being used. Through a public pool a reserve should be developed and allocated on appropriate criteria. For example, if an indigent patient is transferred from one medical facility to another one for specialty or tertiary services I envision that the first county government should be responsible for the expenses of the transferred patient and not the facility to which the transfer was made in another municipality.

(2) *Hospitals*. Recently the American Hospital Association and the Catholic Health Association acknowledged that the tax-exempt status of hospitals carries with it community obligations that include some responsibility to make provisions for the poor, even in an environment dominated by efforts to control costs. Although uncompensated care (the sum obtained when the cost of providing charity care is added to the bad debts owed by patients to providers) ranges from 11.5% for public nonfederated hospitals to 7.3% for private nonprofit hospitals down to 3.1% for for-profit hospitals on a national basis, our numbers should be studied across the state. We should look at the Public Medical Trust Fund created by Florida's legislature. There an annual assessment on hospitals of 1% of their net operating revenues and a similar state appropriation funds additional care through county public health units.

(3) *Pharmaceutical industry*. Just as providers

and society have a role, one should look at drug houses to share this burden. Certain drugs — e.g. cimetidine (SKF) and ranitidine (Glaxo) have experienced repeated price increases since being introduced more for profit than for production costs. We should examine whether drugs for indigents might be donated either through pharmacies or through county health departments in turn for tax deductions or credits based on an equitable formula for the drug houses. One consideration might be that only those on the Medicaid formulary would be eligible for "donation." Not infrequently a patient will require two or three drugs which can easily cost sixty to one hundred dollars per month. Likewise, equipment and supplies must be available when necessary for the indigent.

(4) *Physicians*. Just as all physicians have a social responsibility for Medicaid, for which there is a reimbursement mechanism, they have a similar one to provide indigent care. The proposal which I offer is that this care be calculated at Medicaid-Medicare rates and be declared as a business expense on profit/loss statements. By considering this service as an expense according to accounting principles, one can receive credit for the time, personnel and supplies so necessary. For this concept, I am not suggesting that "bad debt" be given any recognition; rather a provider must decide at the onset that the care rendered is "indigent" and not subject to any collection efforts. Earlier I emphasized that we have a societal duty to collectively perform these tasks; yet a carrot in recognition of these services would certainly be more palatable to many physicians.

(5) *Individuals*. My final thesis is that the individuals have a responsibility for their medical care costs and should be expected to pay according to their ability. The sliding scale used in the Rural Health Initiatives or similar graduated options should be explored. Some states are exploring strategies to design policies that provide health insurance to people without coverage so that they can pay their bills.

Although indigent care is a volatile complex issue, physicians have the opportunity to suggest a model for handling the indigent patients in our state. Through a shared responsibility by each of five parties we can solve the problem not by federal mandate but rather by working collectively together in our own communities.

A. Jerald Jackson, M.D.
415 South 28th Avenue
Hattiesburg, MS

Medico-Legal Brief

Law That Freezes Amounts Charged by Physicians to Medicare Patients Not Unconstitutional, Court Rules

Sections of the Deficit Reduction Act freezing amounts that could be charged by physicians to Medicare beneficiaries were not unconstitutional, a federal trial court in Indiana ruled.

Several physicians, patients, the Indiana State Medical Association, and the American Medical Association brought an action challenging the constitutionality of sections of the Deficit Reduction Act. One provision of the Act froze both the prevailing and the customary charge levels for the 15-month period beginning July 1, 1984. Physicians were not permitted to charge at levels higher than the levels set for the 12-month period prior to July 1, 1984. Non-participating physicians were limited to charging Medicare patients no more than their actual charges for the calendar quarter beginning on April 1, 1984.

In addition, the Act provided that participating physicians had to accept all Medicare payments by assignment of benefits. Prior to the Act, a physician could either accept assignment of benefits or could charge the patient directly. If the physician chose not to accept assignment, there was no limitation on the amount he could charge a Medicare beneficiary. Under either situation, Medicare would normally pay 80 percent of the reasonable charge, and the Medicare patient would be liable for the balance.

The Act encouraged physicians to become participating physicians by mandating that the Secretary of Health and Human Services publish a directory of participating physicians to be made available to all Medicare beneficiaries and to provide for the electronic receipt of claims from participating physicians enabling them to have their claims processed more quickly.

In a five-count complaint, the physicians and the AMA claimed that the freeze on the amount that non-participating physicians may charge their patients discriminated against them in an arbitrary and irrational fashion in violation of the equal protection provision. The second count claimed that patients would be unable to obtain medically necessary services and treatments from the physicians of their choice, thereby depriving them of their rights of privacy, personal liberty, equal protection, due-process, and protection against arbitrary and capri-

(continued on page 57)

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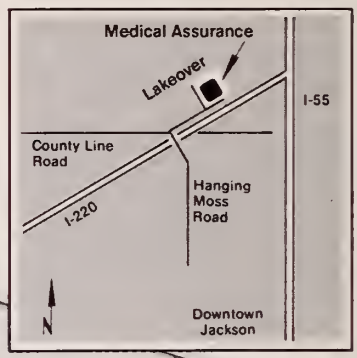
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Legislature Considers Bills on Health Issues

Representatives of various professional and business groups have testified at House and Senate committee hearings in support of bills to place a cap on punitive and other non-economic damages. MSMA has been active in the coalition which supports the bills. Strong opposition by the Mississippi Trial Lawyers Association has centered around attacks on the insurance industry. Among other charges, the MTLA has questioned the justification for the high rates for liability insurance and has called for an investigation.

The companion bills on liability insurance are only two of the many health-related proposals before this session of the Mississippi Legislature, which thus far has been characterized by unprecedented action.

MSMA's Council on Legislation has voted to support a number of other bills, including: a bill to create a risk pool to provide health insurance to high-risk individuals; a proposal to increase the penalty for practicing law or medicine without a license; a measure to provide for reporting to the Medical Licensure Board the surrender of medical staff privileges while investigation is pending; a proposal to increase the per diem paid to hospitals furnishing indigent care; a bill to prohibit smoking in state-owned hospitals; a plan to authorize the writing of policies by a Joint Underwriting Association for medical malpractice insurance; and a bill to provide additional grounds for suspension, revocation or non-issuance of a medical license.

The Council opposes bills to enlarge the scope of practice for chiropractors and to allow opticians to fit contact lenses.

A mandatory seat belt law supported by MSMA was rejected by the House early in the fourth week of the session, but representatives did approve a bill requiring parental consent for abortions performed on minors. That measure is modeled after a Missouri statute which has withstood a U. S. Supreme Court challenge. The bill provides for a fine of up to $500.00 and a six-month jail term for a physician who does not comply with the notification requirements.

In Senate action, a bill to reorganize the coroner system and streamline the office of the State Medical Examiner received a favorable report from a subcommittee and now faces action by the Senate Judiciary Committee.

At press time a major deadline was approaching, and any general bill or constitutional amendment not reported by the early February deadline would die unless revived by a two-thirds vote of both chambers.

MSMA members are encouraged to read the weekly *MSMA Legislative Report* for regular review of legislative action. The Regular Session of the Mississippi Legislature is scheduled to adjourn April 6.

H. Cody Harrell 1935-1985

H. Cody Harrell, MSMA Assistant Executive Secretary and Comptroller, died on December 30, 1985, after a lengthy illness. Cody joined the association as comptroller in 1969. The House of Delegates recognized and commended him for his long and devoted service to the association at the 1985 Annual Session.



Dr. Norman C. Nelson, vice chancellor for health affairs and the School of Medicine, honored local physicians who have been on the medical school clinical faculty since 1955 at a luncheon. Among the 37 cited for their contributions to medical education in Mississippi for the last three decades were: first row from left, Dr. Rush Netterville, Dr. Cy Johnson, Dr. W. Coupery Shands, Dr. Raymond Martin, Dr. James L. Royals, and Dr. Curtis Caine; back row from left, Dr. J. Harold Conn, Dr. Willard Boggan, Dr. Charles Caccamise, Jr., Dr. Raymond Grenfell, Dr. W. H. Rosenblatt, Dr. Julian Weiner, Dr. Elmer J. Harris, Dr. William Weiner, Dr. Howard Nichols, Dr. Samuel B. Johnson, and Dr. Donald Imrie.

UMC Pays Tribute To 30-year Clinical Faculty

Thirty-seven local physicians who had been on the University of Mississippi School of Medicine clinical faculty since the health sciences campus opened in 1955 were honored recently at a special luncheon at the Medical Center.

Dr. Norman C. Nelson, vice chancellor for health affairs and dean of the School of Medicine, cited the group for their "generous service to the School of Medicine's programs for health professional education, patient care and research since 1955."

Local physicians in the group are: Dr. J. Harold Conn, Dr. John Vardaman Cockrell, Dr. W. Coupery Shands, Dr. Hans Karl Stauss, Dr. Donald T. Imrie, Dr. Cyrus C. Johnson, Dr. Samuel B. Johnson, Dr. Harvey Johnston, Dr. Raymond S. Martin, Jr., Dr. Rush E. Netterville, Dr. Julian Wiener in the Department of Surgery;

Dr. Charles Lamar Neill and Dr. Walter Ridgway Neill in the Department of Neurosurgery;

Dr. Willard Henry Boggan, Jr., Dr. John Francis Busey, Dr. Charles William Caccamise, Jr., Dr. Carlton R. Daniel, Jr., Dr. Benjamin Perry Folk, Dr. Earnest L. Posey, Jr., Dr. Raymond F. Grenfell, Dr. William Harold Rosenblatt, and Dr. Arthur W. St. Clair in the Department of Medicine;

Dr. Ross Frederic Bass, Dr. William L. Crouch, Dr. James L. Royals, Dr. Walter H. Simmons, Dr. C. G. Sutherland, Dr. Blanche Lockard and Dr. William B. Wiener in the Department of Obstetrics and Gynecology;

Dr. Wilfred Q. Cole, Dr. Jim Gilbert Hendrick, Dr. Noel C. Womack and Dr. Howard Hunter Nichols in the Department of Pediatrics;

Dr. Curtis W. Caine in the Department of Anesthesiology;

Dr. Elmer J. Harris, Dr. Robert P. Henderson and Dr. James M. Packer in the Department of Radiology.

In addition to the School of Medicine, the Medical Center includes Schools of Nursing, Health Related Professions and Dentistry; graduate programs in the medical sciences; and the 545-bed University Hospital, teaching hospital for all programs.



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Advanced Communications System Developed at Medical Center

The University of Mississippi Medical center (UMC) and Mobile Communications Corporation of America (MCCA) and its Boston, Mississippi, based affiliate Advanced Interactive Systems, Inc. (AIS) have entered into a joint development project for a paging communications and message management system at UMC.

The project will result in the first installation in Mississippi and its surrounding states of an advanced, computer-based, multi-function communications management system designed specifically for hospital requirements.

According to MCCA and AIS, the total value of the system to be installed at the Medical Center is approximately $125,000.

"This is an exciting event for Mississippi and for the University," said R. Gerald Turner, Chancellor of the University of Mississippi. "Medical centers like ours have important and unique communications needs. The technically advanced paging system we'll have as a result of the MCCA/AIS installation will be unlike anything currently used in Mississippi, Alabama, Louisiana, Arkansas or Tennessee."

As a statewide center for health care services, UMC must maintain reliable communication with its 4,300-member staff. "Very often, lives are literally at stake and reliable, fast communication is imperative," said Dr. Norman C. Nelson, Vice Chancellor for Health Affairs. "That's why the new system MCCA and AIS are installing is so important to us. We are happy to work with MCCA and AIS in this joint effort."

The system UMC will receive is an AIS micro computer-based multiple function communications system. It combines paging, personnel directories, staff availability (doctor's registry), on-call schedules, and patient information services. The system should become operational in the first quarter of 1986, Dr. Nelson said.

"Like all Mississipians, we at MCCA understand and appreciate what UMC means to the people of Mississippi," John N. Palmer, president of MCCA, said. "UMC educates, conducts research and provides quality health care, thereby greatly contributing to our quality of life."

"In the medical services industry, state of the art technology in paging and message communications plays an integral role in a hospital's ability to respond effectively to patient's needs," Palmer said.

Palmer added that management of MCCA and AIS will work with Medical Center officials to develop new features for AIS systems using the UMC system as a prototype.

MSMA 118th Annual Session
June 4-8, 1986
Biloxi, MS

DEATHS

EGGER, JOHN G., Drew. Born West Point, MS, March 7, 1915; M.D., University of Tennessee Center for Health Sciences, Memphis, 1940; interned Methodist Hospital, Dallas, one year; died Oct. 20, 1985, age 70.

NEELY, WILLIAM A., Jackson. Born Memphis, TN, June 10, 1921; M.D., Harvard Medical School, Boston, 1951; interned Barnes Hospital, St. Louis, MO, one year; surgery residency, University of Tennessee, Memphis, 1952-57 and UMC, Jackson, MS, 1955-57; died Nov. 19, 1985, age 64.

PITTMAN, JAMES J., Tylertown. Born Tylertown, MS, Sept. 30, 1901; M.D., Tulane University School of Medicine, New Orleans, 1933; interned Southern Baptist Hospital, New Orleans, one year; ob-gyn residency, Tulane, 1939, and Mayo Clinic, Rochester, MN, 1945-51; died Dec. 8, 1985, age 84.

RUSH, H. LOWRY, JR., Meridian. Born Meridian, Nov. 11, 1925; M.D., University of Pennsylvania School of Medicine, Philadelphia, 1951; interned Charity Hospital, New Orleans, one year; died Nov. 16, 1985; age 60.

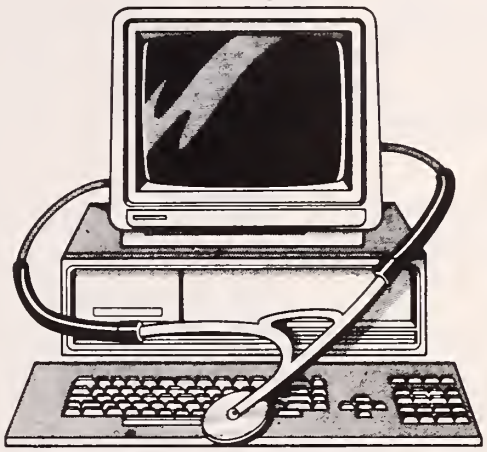
THOMPSON, ROBERT LEWIS, Jackson. Born Hattiesburg, MS, Sept. 30, 1929; M.D., University of Mississippi School of Medicine, Jackson, 1958; interned United States Naval Hospital, Great Lakes, IL, one year; anesthesiology residency, USNH, St. Albans, NY, 1959-61; died Nov. 25, 1985, age 56.

WILEY, L. W., SR., Forest. Born Pisgah, MS, Oct. 17, 1903; M.D., University of Tennessee School of Health Sciences, Memphis, 1931; died Oct. 20, 1985, age 82.

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Atlanta, Georgia 30345

NEW MEMBERS

BEDILLION, T. MARK, Vicksburg. Born Midland, TX, May 29, 1956; M.D., University of Texas Medical Branch, Galveston, 1982; interned and anesthesia residency, Scott & White Hospital, Temple, TX, 1982-85; elected by West Mississippi Medical Society.

BYRD, W. HALE, Jackson. Born Lucedale, MS, May 26, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned and family medicine residency, University Medical Center, Jackson, 1979-82; elected by Central Medical Society.

CESARE, C. DAVID, SR., Clarksdale. Born Orange, TX, Aug. 25, 1954; M.D., University of Mississippi School of Medicine, Jackson, 1982; interned and ob-gyn residency, University Medical Center, Jackson, 1982-85; elected by Clarksdale and Six Counties Medical Society.

GILLIAM, LARRY S., Hattiesburg. Born Los Angeles, Oct. 29, 1948; M.D., Emory University School of Medicine, Atlanta, 1981; interned University of Oregon Health Science Center, Portland, one year; anesthesiology residency, University of Texas Medical Branch, Galveston, 1983-85; elected by South Mississippi Medical Society.

HOUSTON, GERRY ANN. Jackson. Born Baldwin, MS, July 16, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned, medicine residency, and fellowship in hematology-oncology, University Medical Center, Jackson, 1978-83; elected by Central Medical Society.

JOINER, THOMAS E., Jackson. Born Memphis, Dec. 1, 1954; M.D., University of Mississippi School of Medicine, Jackson, 1982; interned and family medicine residency, University Medical Center, Jackson, 1982-85; elected by Central Medical Society.

KENDIG, RONALD J., Jackson. Born New Jersey, Sept. 28, 1950; M.D., University of Maryland School of Medicine, Baltimore, 1977; interned University of Maryland Hosp., Baltimore, one year; orthopedic surgery residency, Union Memorial Hospital, Baltimore, 1978-82; elected by Central Medical Society.

LYONS, REEDA A., New Albany. Born Holly Springs, MS, May 21, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned and pediatric residency, University Medical Center, Jackson, 1979-1982; elected by Northeast Mississippi Medical Society.

NEWCOMB, MARTIN M., Jackson. Born Hattiesburg, MS, Aug. 29, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned and medicine residency, UMC, Jackson, 1973-76; fellowship in hematology-oncology, same, 1976-79; elected by Central Medical Society.

RANDOLPH, RICHARD C., Brandon. Born Batesville, MS, Oct. 8, 1957; M.D., University of Mississippi School of Medicine, Jackson, 1982; interned University Medical Center, Jackson, MS, one year; family medicine residency, Mississippi Baptist Medical Center, Jackson, 1983-85; elected by Central Medical Society.

REED, ALPHONSE M., Fayette. Born New Orleans, March 9, 1950; M.D., Louisiana State University School of Medicine, New Orleans, 1982; interned and internal medicine residency, University Medical Center, Jackson, MS, 1982-85; elected by Homochitto Valley Medical Society.

VANDERGRIEND, ROBERT A., Jackson. Born Sheldon, IA, Sept. 20, 1952; M.D., University of Florida College of Medicine, Gainesville, 1978; interned and orthopedic surgery residency, University of Florida, Gainesville, 1978-83; elected by Central Medical Society.

POSTGRADUATE CALENDAR

March 6-7
RENAL UPDATE
Ramada Renaissance, Jackson

March 20
ONCOLOGY UPDATE
University Medical Center

April 5
SEVENTH ANNUAL SPRING SONIC SYMPOSIUM
Ramada Renaissance, Jackson

April 9-12
FAMILY PRACTICE UPDATE
Ramada Renaissance, Jackson

April 19
NUCLEAR MEDICINE UPDATE
University Medical Center

Physicians in Mississippi
have made a commitment
to maintaining quality medical
care at a reasonable cost.

Both public providers
and private practitioners
are working to insure
that comprehensive care is
available to Mississippi people
through efficient use of resources.

One way to meet health needs
at a stable or reduced cost
is home health services.



The Mississippi State Department of Health has been providing home health services as defined in the Medicare Law on a statewide basis since 1969. Now **every county health department is a state-licensed, Medicare/Medicaid-certified home health agency.**

Through the 82 county health departments, home health services staff work with local physicians, hospitals, and nursing homes to provide alternative care for patients who might otherwise have to remain in the hospital or live in a nursing home. If appropriate to meet the patient's nursing and related needs, home health services is less expensive and also more acceptable to the patient. Yet **every patient remains under his doctor's orders.**

Throughout the course of care for each patient, the public health nurse consults with the physician. She must review the therapy regimen at least every 60 days and report in writing to the physician. The Mississippi State Department of Health goal is to offer the best possible home health services provided by qualified staff who are sensitive to the physician's therapy plan and to the needs of each patient.

For general information or discussion,
call Home Health Services toll-free
1-800-228-2642
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Or call the home health nurse at your county health department.

Mississippi State Department of Health

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PERSONALS

ORLANDO ANDY of UMC presented a paper at a meeting in New York of the Eastern Association for Electroencephalographers.

WILLIAM BATES of UMC was guest speaker at the Southwestern Gynecologic Assembly in Dallas and was visiting professor at the University of Tennessee Center for the Health Sciences in Memphis, where he also served as examiner for the American Board of Obstetrics and Gynecology.

BLAIR BATSON of UMC chaired the government affairs committee of the American Academy of Pediatrics in Washington, DC.

ROBERT W. CALCOTE of Jackson has been certified as a diplomate of the American Board of Dermatology.

H. REED CARROLL of Grenada was guest speaker at a seminar for the public on coping with cancer.

J. ROBERT COLTHARP of Hattiesburg recently was named a fellow of the American College of Surgeons.

DAVID CRAWFORD of UMC was guest speaker at the sixth Central American and Caribbean Congress on Oncology in San Jose, Costa Rica, and chaired a committee meeting at the Disease Committee Scientific Retreat of the Southwest Oncology Group in Dallas.

LARRY H. DAY of Hattiesburg recently was named a fellow in the American Academy of Otolaryngic Allergy.

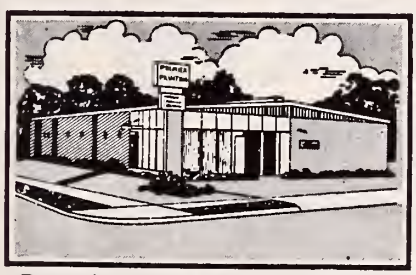
CHUCK GUICE of Hattiesburg has been elected to fellowship in the American Academy of Otolaryngic Allergy and the American Academy of Otolaryngology-Head and Neck Surgery.

JOE HERRINGTON of Natchez has been elected chief of staff at Natchez Hospital-Humana. Other officers are VANN CRAIG, vice-chief, and KENNETH STUBBS, secretary.

JEFF HOLLINGSWORTH of Jackson is president of the

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American Heart Association in Mississippi for 1986. T. D. LAMPTON of Jackson is president-elect and EDWARD HILL of Hollandale is vice president.

JAMES HUGHES of UMC recently taught a continuing education course in Davos, Switzerland.

JOHN JACKSON of UMC made a presentation at a meeting of the American Society of Hematology in New Orleans.

ELDON D. MCCLAIN has been named chief of staff at Biloxi Regional Medical Center. Other officers are NOEL JOHNSON, vice president, and DOUGLAS COSENTINO, secretary-treasurer.

ELLIS M. MOFFITT of Jackson appeared on ETV's "Access" series for a discussion of health care costs in Mississippi.

TRAVIS RICHARDSON of Drew has been appointed to the Mississippi Board of Corrections by Gov. Bill Allain.

LAWRENCE J. RUSSO has associated with DANIEL J. ENGER of Pascagoula for the practice of orthopedic surgery.

SPENCER SCHREITER of Tupelo spoke at a seminar for health care personnel on the subject of AIDS.

KELLY S. SEGARS of Iuka has been named president-elect of the medical alumni chapter of the University of Mississippi Alumni Association.

A. P. SORIANO has associated with ANITA BATMAN of Pontotoc for the practice of general medicine and surgery.

TOUFIK TABABBARA has opened his practice of general surgery in Indianola.

MAX TAYLOR of Tupelo spoke on AIDS at a North Mississippi Medical Center seminar for health care personnel.

HENRY TYLER of Jackson was a guest on ETV's "Access" series for a discussion on the treatment and prevention of heart disease.

LAMAR WEEMS of UMC chaired the Council on Urology meeting of the National Kidney Foundation in New Orleans.

WINFRED WISER of UMC was examiner for the American Board of Obstetrics and Gynecology in Chicago.



Be prepared, Doctor. More patients will be asking about colorectal cancer. According to a survey* conducted by the American Cancer Society, many people would like to receive more information about colorectal cancer, and 83% said they would want to be checked for it. Further, they are learning that this cancer can be detected *before* symptoms appear. The present cure rate is 44%. The cure rate *could* be as high as 75%, with early detection and appropriate management.

For asymptomatic persons the Society recommends annual digital rectal examination at age 40 and over; at age 50 and over, an annual stool blood test, as well as sigmoidoscopy every three to five years, following two initial annual negative sigmoidoscopies.

We're here to help. You can reach us at your local American Cancer Society office or write to our Professional Education Department at National Headquarters, 90 Park Avenue, New York, N.Y. 10016. Ask about the Society's Colorectal Check program of professional and public education for the early detection of colorectal cancer.

AMERICAN CANCER SOCIETY®

MEDICO-LEGAL BRIEF

(continued from page 45)

cious governmental action. In count three, the Medicare beneficiaries claimed that the government breached its contractual promise that they would be entitled to freely choose among qualified physicians and that they would receive equivalently-calculated reimbursements for physicians' services regardless of their choice.

In count four, certain physicians and the two medical associations claimed that the failure to release information essential to physicians' decisions on whether to become participating physicians caused the October 1, 1984, deadline to be fundamentally unfair and in violation of the Due Process Clause of the Fifth Amendment. Finally, in count five, the physicians and medical associations asserted that a letter defining the phrase "actual charges for the calendar quarter beginning on April 1, 1984" violated the requirements of the Administrative Procedure Act because no prior public notice and opportunity for comment was given.

Dismissing the claims in counts two and three that as a result of the fee freeze, Medicare patients will be unable to obtain medical services from the physicians of their choice, the federal trial court said that there was no evidence that any of the patients had been denied the services of a physician of his or her choice because the patient was a Medicare patient. They failed to demonstrate that anyone had denied them access to physicians of their choice. Applying the rational relationship test to the other three counts, the trial court said that the fee freeze was rationally related to Congress's reasonable objective of controlling the federal deficit and Medicare costs.

The "Dear Dr." letter sent by the Secretary to physicians defining the phrase "actual charges for the calendar quarter beginning April 1, 1984" was not a rule or regulation that was subject to the notice and comment provisions of the Administrative Procedure Act. The letter, which interpreted the meaning of the term "actual charges" as used by Congress in the Deficit Reduction Act, may not be the only fair or desirable interpretation of the statute, the court said. However, it was sufficiently reasonable to conform with both the plain language and intent of the act.

The court entered judgment in favor of the government on the claims based on equal protection and violation of the Administrative Procedure Act. — *American Medical Association v. Heckler,* 606 F.Supp. 1422 (D.C., Ind., April 18, 1985)

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References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus,* volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made.

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The Mississippi Disability Determination Services now has a program available for medical society meetings and hospital staff meetings. The purpose of this program is to explain how the disability determination process works, its historical background, its basis in legality and its documentation requirements. Any group interested in this presentation should also contact the Medical Relations Office.

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Index to Advertisers

Avanti 49
Ayerst Laboratories 34A, 34B, 34C, 34D

Burroughs Wellcome **10A**

Canton Exchange Bank 55
Curtis 1000 Information Systems 51

Disability Determination Service **13**

Future Systems **11**

Harreld Chevrolet 57
F. Edward Hebert Hospital **12**

Eli Lilly and Co. **10B**

Medical Assurance Co. of Miss. 46
Miss. State Department of Health 53

MSMA Benefit Plan and Trust ..... second cover

Oschner Hospital 32

Premier Printing 55
Puckett Laboratory 37

Roche Laboratories ..... **third, fourth covers**

Smith Kline Beckman **10D,** 54A

University of Alabama **6, 7**
The Upjohn Co. **10C**
U. S. Air Force **4**
U. S. Army Reserve 38

Jon Wimbish and Associates **8**

Thomas Yates and Co. 54

MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 15-19, 1986, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

State and Local

Mississippi State Medical Association, 118th Annual Session, June 4-8, 1986, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, June 25-28, 1986, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, February, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, January, May, and November. H. S. Barrett, Secy., P.O. Box 1810, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington, Yazoo.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, Secy., Mail: Ms. Jenkins, P.O. Box 4053, Meridian 39305. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, Meetings scheduled quarterly. Fred G. Emrich, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, January. Charles S. Watras, 612 Summit St., Winona 38967. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, September, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Steve Parvin, Secy., 106 Strange Rd., Starkville 39759. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 1st Wednesday, February, April, June, August, October, December. John J. McCloskey, Secy., 3003 Short Cut Rd., Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. George R. Bush, Secy., 307 S. 13th Ave., Laurel 39440. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

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1559 Lafayette St.
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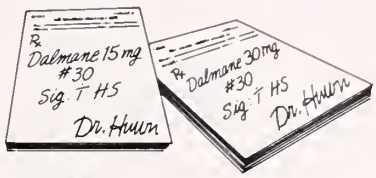
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JOURNAL of the MISSISSIPPI State Medical Association



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The Journal of the Mississippi State Medical Association is owned and published monthly by the Mississippi State Medical Association, founded 1856, at 735 Riverside Drive, Jackson, Mississippi 39202. Subscription rate, $25.00 per annum; $35.00 per annum for foreign subscriptions; $2.25 per copy, as available. Advertising rates furnished on request. Printed by The Ovid Bell Press, Inc., Fulton, Missouri. Second-class postage paid at Jackson, Mississippi, and at additional mailing offices. POSTMASTER: Send address changes to Mississippi State Medical Association, 735 Riverside Drive, Jackson, Mississippi 39202.

CONTENTS

ORIGINAL PAPERS

Repeat Aortocoronary Bypass: Indications and Results — **61** Martin H. McMullan, M.D. and Thomas L. Kilgore, M.D.

Outstate Neurology Clinics for the Medically Indigent — A Continuing Need — **65** Armin F. Haerer, M.D.

Mississippi Adopts National Medical Standards for Measurement of Medical Malpractice — **68** Denzil Y. Causey, Jr.

EDITORIAL

Litigiousness a Sign of Social Decay — **71** W. Moncure Dabney, M.D.

THIS MONTH

Marry a Pharmacist's Daughter — **70** The President Speaking

71 Medico-Legal Brief
72 Comment
73 Medical Organization
77 New Members
81 Personals

About the Cover: In his President's Page article, Dr. Ralph Brock offers some suggestions for safeguards and management of prescriptions.

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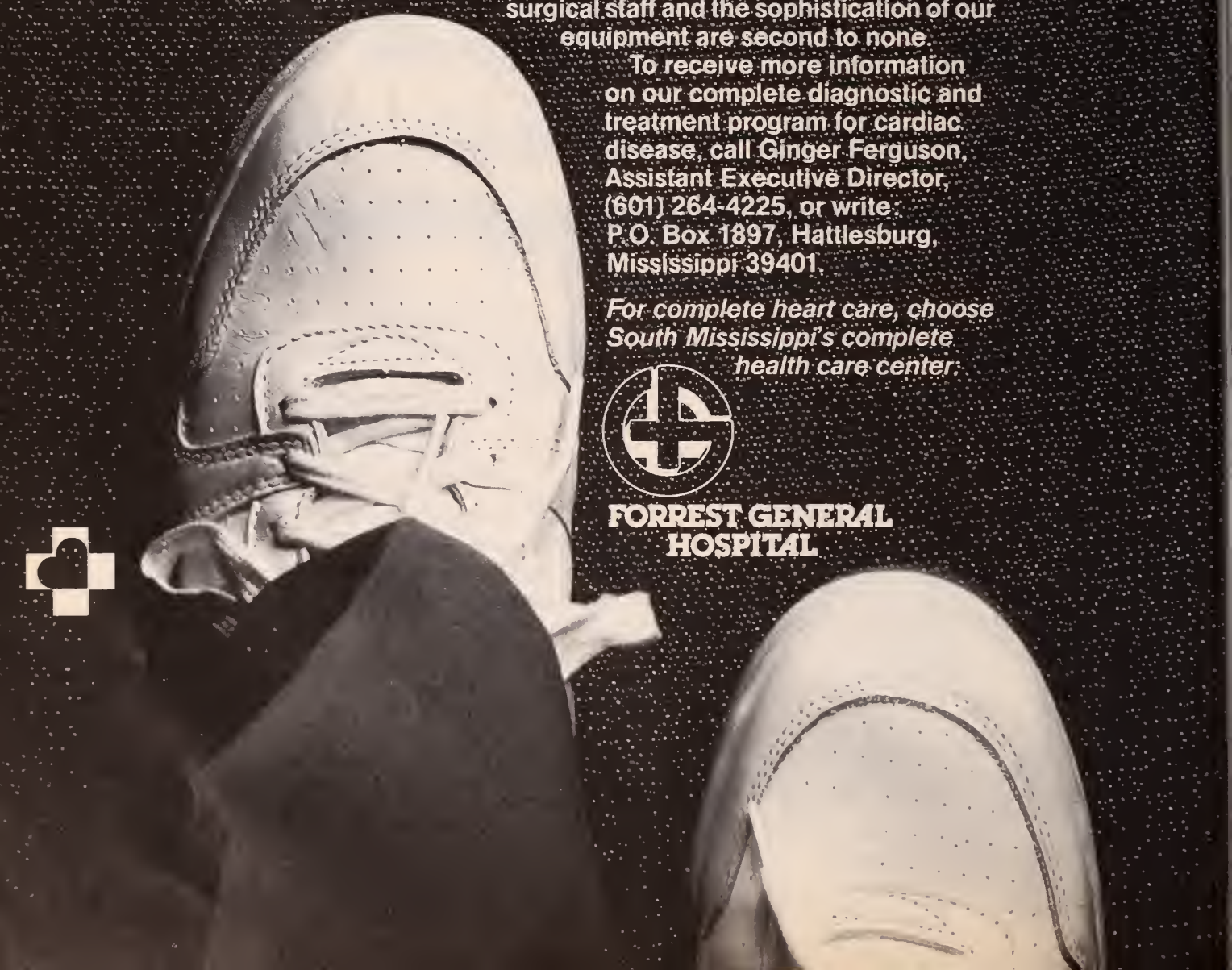
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NEWSLETTER

March 1986

Dear Doctor:

In January the Board of Medical Licensure adopted the following amendments to the regulations governing the practice of physicians, osteopathic physicians and podiatrists:

> "An applicant must have, within ten (10) years prior to date of application, taken and successfully passed a written medical competency examination approved by this Board. An applicant who possesses all of the qualifications for licensure by reciprocity/endorsement with exception of having successfully passed a written medical competency examination within ten years prior to date of application, shall, nonetheless, be considered eligible for licensure by reciprocity/ endorsement if such applicant takes and successfully passes Component II of the Federation Licensing Examination (FLEX) as administered by and under the auspices of the Board."
>
> "Any physician, osteopathic physician or podiatrist who is licensed or receives a license to practice medicine in this state and thereafter moves his medical practice to a location different from that noted in the application upon which he received a license, shall immediately notify the Board of the change of location of his intended practice. Failure to notify within 30 days could result in disciplinary action."

Cost of a medical degree from the University of Mississippi may increase by $1,000, university officials said last month. Currently at $5,000, the annual tuition already makes UM the most expensive public medical college in the southeast. Cuts in state appropriations for fiscal 1987 also force a continued freeze on UMC hiring, reductions in services, and a zero equipment budget.

Reminder: MSMA's 118th Annual Session is only a couple of months away. Plan now to bring your family and join your colleagues June 4-8, in Biloxi.

Sincerely,

Patsy Silver

Patsy Silver
Managing Editor



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DATELINE

Eye Care Project Will Aid Seniors

Chicago, IL - More than 200,000 senior citizens are expected to be referred to volunteer doctors participating in an American Academy of Ophthalmology project of eye care for the elderly. Some 8,000 physicians across the country have agreed to treat patients for Medicare or other insurance assignment as payment in full and also will donate services to other patients who have no insurance.

Medical Care Costs in 1985

Chicago, IL - The cost of medical care grew at a slightly faster pace in 1985 than it did in 1984, according to a report on the Consumer Price Index issued by the AMA Center for Health Policy Research. The report shows that, although the overall rate of inflation for 1985 was 3.8%, the cost of all medical care rose by an average of 6.7%. In 1984, those figures were 4% and 6.1%, respectively.

Millions Lack Adequate Insurance

Chicago, IL - More than 50 million Americans lack adequate health care insurance coverage, according to an AMA Council on Medical Service report in the Feb. 14 JAMA, which prompts a call for exploration of methods to provide more adequate financing for such patients. More than 75% of doctors provide some free or reduced-fee care, and the average per-hospital amount in charity care is $300,000 annually, plus $700,000 in bad debt write-offs.

AVMA Cautions Against Keeping Ferrets as Pets

Schaumburg, IL - People who want ferrets as pets should know these increasingly popular animals can be dangerous to infants and small children, warns the American Veterinary Medical Association (AVMA). The AVMA reports that several children, including a 29-day-old infant and a six-month-old child, have been attacked by "pet" ferrets. In all cases, the ferrets were found to be free of rabies. Some cities have prohibited the keeping of ferrets as pets.

Radial Keratomy Patients Report Results

Chicago, IL - More than 350 patients who had undergone radial keratomy were surveyed by researchers one year after the procedure. Only 10% registered dissatisfaction, while 42% said they were moderately satisfied and 48% said they were very satisfied. The study, reported in the March Archives of Ophthalmology, also found that 34% of patients reported having some difficulty following surgery.



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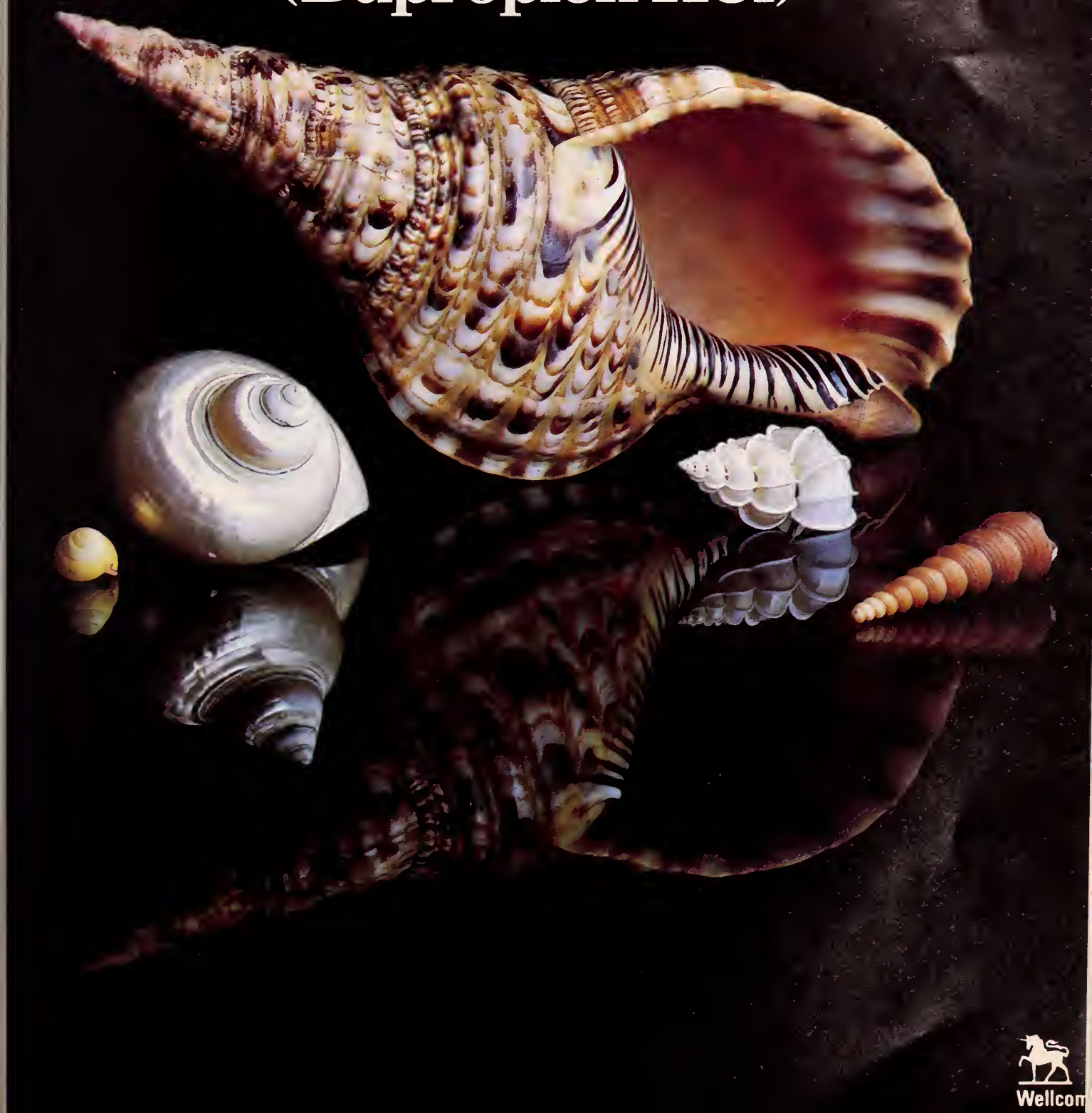
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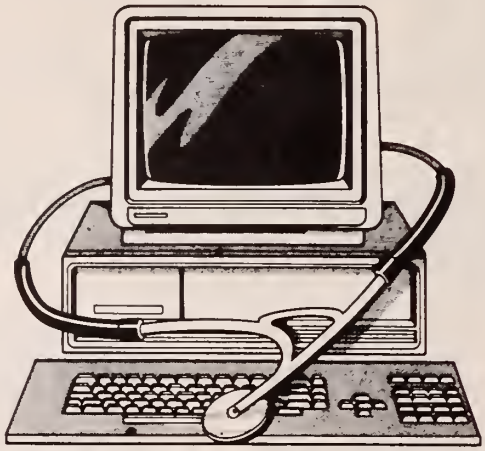


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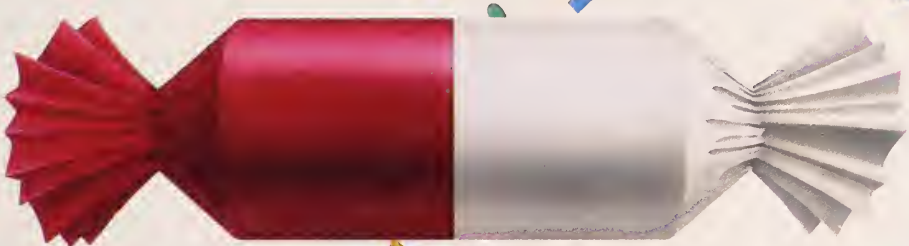
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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
March 1986, Volume XXVII, Number 3

ORIGINAL PAPERS

Repeat Aortocoronary Bypass: Indications and Results

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Jackson, Mississippi

BECAUSE THERE IS no cure for atherosclerosis, aortocoronary bypass is considered a palliative procedure. Any patient undergoing this operation immediately becomes a potential candidate for a repeat bypass procedure at a future date. There are now approximately 100,000 patients a year who undergo aortocoronary bypass in this country. At the Mississippi Baptist Medical Center we have performed the procedure in over 3400 patients. These numbers represent a tremendous repository of patients for follow-up and consideration for another operation. This study was undertaken to examine our indications and results including late follow-up in patients undergoing repeat aortocoronary bypass.

Patients and Methods

At the Mississippi Baptist Medical Center 3390 patients have undergone isolated primary aortocoronary bypass between January 1971 and March 31, 1985 with an operative mortality of 2.0%. Through March 31, 1985 we have performed 114 repeat aortocoronary bypass operations in 111 patients. One patient underwent three repeat operations. The average age of the patients was 58 years (range 36 to 74). The average interval between the first and second operation was 6.7 years (range 3 months to 163 months). There were 102 males. Sixty-five (59%) patients gave a smoking history and only 37 had stopped smoking at the time of the second operation. Forty-eight (43%) were hypertensive, 9 (8%) were diabetic, 72 (65%) had a history of coronary atherosclerosis in their immediate family, and 48 (43%) had either Type II or Type IV hyperlipidemia. Thirty-three (30%) patients underwent the original operation in another institution.

The technique of myocardial preservation employed was either utilization of cold blood cardioplegia or intermittent aortic cross clamping with moderate hypothermia (28° C). The average cardiopulmonary bypass time was 105 minutes (range 31 minutes to 318 minutes) and the average aortic cross clamp time was 45 minutes (range 0 minutes to 184 minutes). An average of 2.3 grafts per patient were inserted.

Technical complications encountered at surgery related primarily to dense adhesions or progression of atherosclerotic disease. These complications included torn innominate vein (two patients), torn aorta (one patient), transection of a graft with the sternal saw (one patient), acute occlusion of grafts prior to operation (one patient), and embolization of grumous material (one patient). Three patients required re-exploration for bleeding. The intra-aortic balloon pump was utilized in six patients.

There were nine deaths in the series for an op-

Drs. McMullan and Kilgore are engaged in the private practice of cardiovascular surgery in Jackson, MS.

erative mortality of 7.9%. Causes of death are listed in Table I. Ten surviving patients (9%) experienced a perioperative myocardial infarction as evidenced by new Q-waves on electrocardiogram.

Of 102 patients surviving operation seven were lost to follow-up. Ninety-five patients constitute the late follow-up group. Contacts were made by telephone at an average interval after the second operation of 30 months (range 2 months to 133 months). There were four late deaths (4%). Three were sudden and presumed cardiac related. The fourth died at the time of his fourth aortocoronary bypass operation in another institution.



Figure 1. Angiogram of stenotic left anterior descending graft; balloon dilatation of the stenotic lesion; post dilatation angiogram.

TABLE I

CAUSES OF DEATH AT REOPERATION

	No. of Patients
Torn thoracic aorta	1
Embolization of grumous material within graft	1
Acute respiratory distress syndrome and acute renal failure (had streptokinase infusion and angioplasty of LAD graft preoperatively)	1
Acute graft occlusion (16 hours postoperatively)	1
Cardiac failure and bleeding diathesis (fourth aortocoronary bypass operation)	1
Respiratory failure	1
Perioperative infarction and/or left ventricular failure	3

Patients were questioned regarding symptoms of angina and dyspnea. Seventy-four patients (78%) were asymptomatic or had mild symptoms and were considered in NYHC I or II. Fifteen patients (16%) were NYHC III while two patients (2%) were NYHC IV.

Discussion

As increasing numbers of aortocoronary bypass procedures are performed, repeat operations will become more prevalent. It becomes the responsibility of the primary care physician to have a heightened awareness in caring for these patients. Any patient who complains of symptoms suggestive of recurrent angina at any time after aortocoronary bypass, any patient with residual postoperative angina who displays an increase in symptoms, or any postoperative patient who exhibits unstable angina at any time must be evaluated. Evaluation utilizing a simple treadmill exercise test may be sufficient to alleviate the concerns of the patient and his physician. Greater specificity is obtained with use of a Thallium stress test. Radionuclide stress testing is gaining popularity in screening patients with ischemic heart disease. As in any patient with suspected occlusive disease of the coronary arteries, the definitive study for defining anatomy and thus making recommendations for appropriate therapy rests with cardiac catheterization. If a patient exhibits symptoms of angina and/or has a positive stress test combined with suitable coronary anatomy and reasonable ventricular function, he is a candidate for repeat aortocoronary bypass.

There are alternatives in therapy especially if the recurrent disease is not considered life-threatening from an anataomical viewpoint. The treatment of angina utilizing nitrates, beta blockers, and calcium antagonists may be all that is necessary. A small number of patients may be candidates for percutaneous transluminal coronary angioplasty (PTCA) of native vessels or stenotic vein grafts (Figure I) utilizing a surgical team to stand-by in case of untoward events.

Repeat aortocoronary bypass has a higher risk compared to the initial procedure both in terms of operative mortality and perioperative infarction in our hands and in results reported by others.[1-4] There are technical problems which arise related to the adhesions, the grumous material which can embolize,[5] the progression of disease in the native vessels making them less suitable for grafting, and the progressive left ventricular dysfunction, all capable of contributing to an increase in risk.

However, in spite of the increased risk, we have shown the late results of reoperation are good. Late mortality at 30 months is only 4% and 78% of patients are asymptomatic or have only minimal symptoms at follow-up. Thus, all physicians who care for patients who have undergone aortocoronary bypass must be constantly alert to the realization these patients are not cured and may exhibit life-threatening recurrence of their disease at any time. Appropriate evaluation and intervention may not only be life-saving but allow a continuation of a productive lifestyle. ★★★

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Outstate Neurology Clinics for the Medically Indigent — A Continuing Need

ARMIN F. HAERER, M.D.
Jackson, Mississippi

Outstate Neurology Clinics continue to be held at branch health departments throughout Mississippi to serve indigent persons outside the Jackson metropolitan area. Some 8% of the clinic patients are followed for five years or longer. Most of these are epileptics with problems in seizure control and unemployment. The author notes continued need for these clinics.

BECAUSE OF THE ABSENCE of neurologists outside of Jackson and Biloxi, a comprehensive neurology project for rural Mississippi was begun in 1969, to provide access to specialty care for medically indigent persons living away from metropolitan medical centers. The functions and early years of operation of these Outstate Neurology Clinics were described in 1972 in this journal,[1] and in more detail in 1974.[2] About half of the persons seen in the clinics during their early years were epileptics, while the remainder had a variety of neurologic disorders. Sixty percent were under nineteen years of age, and 43% were still being seen after three years and could not be discharged to other care services.

Since that time, a gradual evolution in the pattern of neurologic care in the state of Mississippi has taken place. There are now qualified neurologists in Hattiesburg, Tupelo, Natchez, and on the Gulf Coast, and there are a number of neurologists in the Jackson metropolitan area. There are also more neurosurgeons throughout the state than there were in the early 1970's.

Despite this increase in accessibility to neurologic specialty care, a need for outstate neurology services has continued. Referrals to the Outstate Clinics have not slackened, and more than 600 persons are seen annually in the clinics. The clinic locations have remained essentially the same. They are sponsored by the State Health Department and held in branch health department offices, all of which are more than an hour's driving distance from Jackson.[1] Clinics are staffed by University Medical Center neurologists and residents, and in some locations by local neurologists as well (Hattiesburg, Tupelo).

From the Department of Neurology, University Medical Center, Jackson, MS.

Almost all persons seen in these clinics continue to be medically indigent. In recent years small fees for clinic visits have been charged to those able to pay them. Medications have been supplied at little or no cost when needed, and essential laboratory tests done through the State Health Department.

The purpose of this report is to define the persons who have continued to require the services of these Outstate Clinics for five years or longer, and who cannot be transferred to local medical care or discharged as cured.

Methods

The records of nearly 5,000 persons seen since 1969 in the Outstate Neurology Clinics were reviewed. Records of those individuals followed for five years or longer were selected for further study and analysis.

Personal, social and medical characteristics of persons followed for five years or longer were tabulated. Reasons for the continued need for follow-up of these long-term patients in the clinics were sought.

Results

Table 1 summarizes the general characteristics of the persons followed for more than five years. There were 383 persons, comprising some eight percent of all patients seen in the clinics. Their ages ranged from one to 69 years, with an average of just under 19 years. Sixty percent of the persons followed five years or longer were still being seen in late 1984. The average duration of follow-up for the persons seen five years or longer in the clinics was 8.5 years. The racial composition was somewhat in favor of blacks over whites, but the differences were minor.

The diagnoses of patients followed for five years or longer are detailed in Table 2. The vast majority, nearly 87%, were epileptics. Fifty-two percent were people with epilepsy alone, another 34% had epilepsy plus other neurologic disorders or mental retardation; 13.4% did not have epilepsy. Of the persons who were actually still being seen and had been followed for five years or longer at the end of 1984 (222 altogether), three-quarters were epileptics.

Of the epileptics followed for five years or longer, 61% had paroxsysmal EEG's and another 16% had other EEG abnormalities. Seizure control at the last visit to the clinic was felt to be good (less than two per year) in 50%, fair (two to 12 per year) in 26%, poor (more than 12 per year) in 23%, and uncertain in one percent. Compliance with prescribed seizure medications, based on anticonvulsant assays, was described as good in 40%, fair in 12%, poor in 12% and uncertain in the remainder (on whom recent blood levels were not available).

Table 3 lists the activity status of 383 patients when last seen in the clinics. Employability and total disability were defined according to Social Security regulations. Somewhat over one-third of these individuals were considered employable, but only a very small fraction of the employable ones held jobs when last seen. Some 20% attended regular school, 10% had special education requirements, 3% were in sheltered workshops and nearly 30% were totally disabled at home.

TABLE 1

PERSONS FOLLOWED IN CLINICS FOR MORE THAN 5 YEARS

General Characteristics	
Total number of patients	383
Age range, years, when first seen	1-69
Average age, years, when first seen	18.7
Percent of patients still seen (1984)	60
Average duration of followup, years	8.5
Racial composition, %	
White males	17.0
White females	21.2
Black males	34.7
Black females	27.1

TABLE 2

DIAGNOSES OF 383 PATIENTS FOLLOWED IN CLINICS FOR MORE THAN 5 YEARS, IN %

Epileptics overall	86.6
Major motor (grand mal) seizures only	36.3
Partial or minor seizures only	5.4
Mixed seizures	10.7
Seizures plus mental retardation	20.1
Seizures plus other neurologic disorders	14.1
Non-epleptics overall	13.4
Headaches	2.9
Mental retardation	2.1
Stroke	1.6
Others	6.8

TABLE 3

ACTIVITY STATUS OF 383 PATIENTS WHEN LAST SEEN IN CLINICS; %

Employed or employable*	35.5
Regular school (any level)	19.7
Special education or homebound instruction	10.5
Sheltered workshop	2.9
Totally disabled at home*	29.2
Retired	1.1
Unknown	1.1

* By Social Security criteria

Comments

There continues to be a need for services for persons with neurologic problems, many of them chronic in nature, who do not have access to private neurologists in Mississippi. Despite concerted efforts to transfer patients out of these clinics to general physicians and specialists accessible to them, 8% of the persons in these clinics continue to be followed for five years or longer. The overwhelming majority of these individuals are epileptics. These persons continue to be seen in the clinics despite the fact that they no longer are able to be seen completely free of charge and are encouraged to pay at least part of the costs of their anticonvulsants. The high percent of epileptics followed in the clinics in contrast to persons with other neurologic diagnoses reflects the need of these persons to have regular and prolonged follow-ups. Also, the emphasis in the clinics is on continued follow-up only for persons to whom effective treatment can be offered.

Recurrent seizures or epilepsy are said to afflict some five to seven persons out of every 1,000 in the population at large in the United States.[3] In Mississippi, based on the Copiah County Study,[4] the number appears to be considerably higher. A reasonable estimate is that there are some 25,000 persons in the state at any given time that have a history of recurrent epileptiform attacks.

The epileptics followed in Neurology Outstate Clinics for five years or longer represent a reservoir of persons whose seizures are difficult to control and who have limited or no access to other medical facilities. This type of clinic will have to continue until the employment and rehabilitative resources in the state are upgraded to eliminate the fraction of these longterm seizure patients who are employable but not employed. Full employment would reduce the reservoir of adult epileptics in the Outstate Clinics by approximately one-third. However, some 200 or more individuals needing prolonged followup would still remain in the clinics, even if all the employable persons found jobs and then made themselves available to private medical care. Efforts are being made by the State Health Department at the present time to provide care for indigent epileptic children whose seizures are not difficult to control by way of local health officers in county health clinics. This will reduce the patient load in the neurology clinics somewhat.

The federal Social Security regulations concerning epilepsy are quite stringent. A person has to continue to have one or more major seizures a month despite at least three months of adequate compliance with anticonvulsant regimens. Indigent persons who cannot pay for expensive anticonvulsants or private medical care thus have difficulty in qualifying for Social Security benefits in spite of the fact that they have serious seizures, because they cannot avail themselves of adequate, prescribed medication to ascertain if their seizures can eventually be controlled. Until these regulations change, it is envisioned that there will continue to be a demand for neurologic services across the state of Mississippi, especially for persons with epilepsy who are indigent.

It is hoped that greater participation by outstate neurologists will diminish the need for support of these clinics through the University Medical Center and the State Health Department. However, some need for this type of neurologic care in a sparsely settled rural state will probably continue indefinitely. ★★★

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Mississippi Adopts National Medical Standards for Measurement of Medical Malpractice

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Mississippi State,
Mississippi

In a 1985 split decision,[1] the Supreme Court of Mississippi tightened the standards for practice of medicine in the state by abolishing the locality rule. This rule had measured physicians and surgeons only against practice within Mississippi and a "reasonable distance adjacent to state boundaries." This rule prevented testimony from doctors from New York, Ohio, and California unless they were familiar with local practice. Speaking for the majority, Justice Robertson observed:

> That a patient's temperature is 105 degrees means the same in New York as in Mississippi. Bones break and heal in Washington the same as in Florida, in Minnesota the same as in Texas. An abnormal blood sugar count should be interpreted in California as in Illinois and in Tennessee. A patient's physiological response to an exploratory laparotomy and needs regarding postoperative care following such surgery do not vary from Ohio to Mississippi. A pulse rate of 140 per minute provides a danger signal in Mississippi, the same as it does in Ohio. Bacteria, physiology and the life process itself know little of geography and nothing of political boundaries.

Facts of the Case

The case before the court involved an exploratory laporatomy performed at a Mississippi hospital on a 37-year-old woman who complained of abdominal discomfort diagnosed as an obstruction of the small bowel. The surgery was performed on May 20, 1978 at about noon. She was moved to a recovery room at about 1:35 p.m., where the surgeon remained in attendance until about 2:50 p.m. At that time she was alert and her vital signs were stable. She was then moved to a private room where she expired about 14 hours later (5:00 a.m. the next morning). The evidence indicated that during this interval the surgeon had no further contact concerning the condition of the patient.

The plaintiff was the husband, who remained with his wife from the time of her arrival from the recovery room at 3:00 p.m. until her death the next morning. He twice reported to the nurses that his wife was experiencing difficulty in breathing but was told that this was normal and that patients sometimes make a lot of noise after surgery. When she turned pale or a bluish color he screamed, but it was too late.

An autopsy revealed the cause of death was adult respiratory distress syndrome (cardio-respiratory failure), and that a sponge had been left in the patient's abdominal cavity. While the sponge may ultimately have caused illness, the sponge did not contribute to the death.

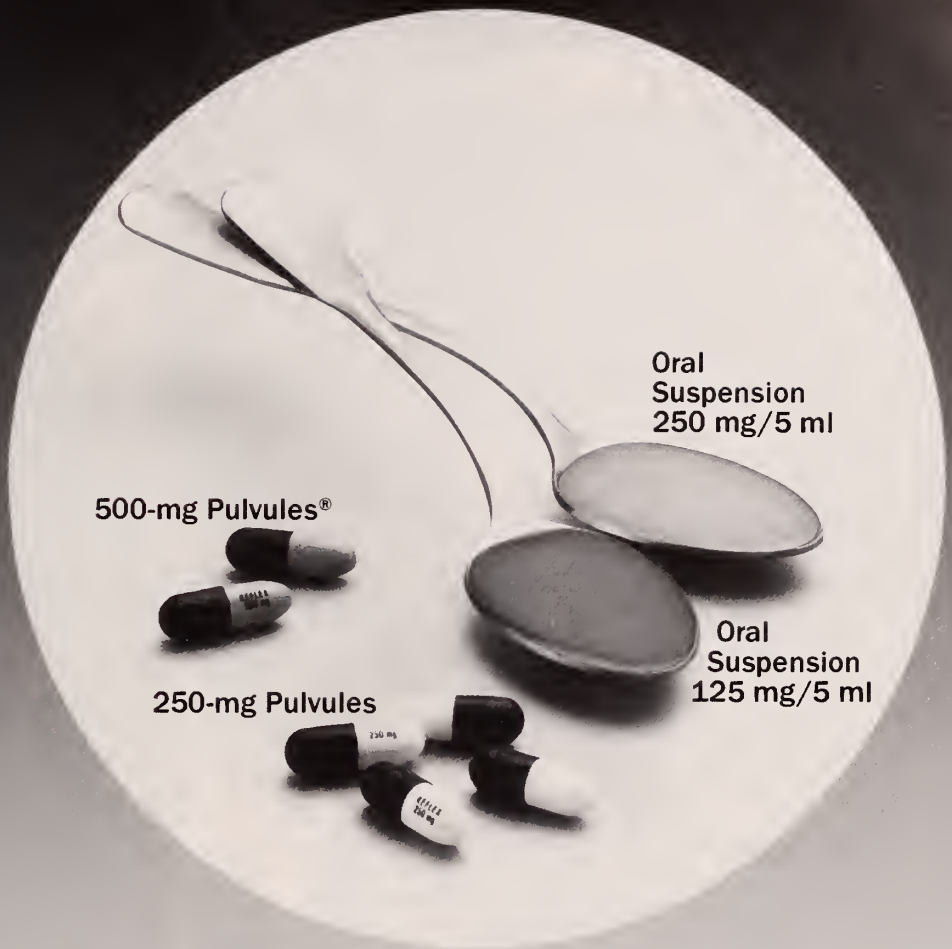
Plaintiff's Case

The theory of the husband's suit against the surgeon was alleged failure to monitor the postoperative course and to give appropriate postoperative instructions to the nursing staff. The husband offered expert testimony from a specialist from Cleveland, Ohio, to the effect that the surgeon had been negligent in not checking on the condition of the patient sometime in the evening, following surgery. He explained different ways of performing this check including

(1) a bedside visit,
(2) a check by a competent physician (not necessarilly a surgeon), or
(3) a check with an experienced Registered Nurse on vital signs and the patient's condition.

The author is professor in the School of Accountancy at Mississippi State University.

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Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment, however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984 2385

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He stated his review of the records indicated no effort had been made to contact any physician, particularly at 4:00 a.m. when the pulse rate was recorded at 140 per minute. This expert also explained an additional thing that doctors do if they feel that nursing services might be unreliable. This is to put limits on the degree to which vital signs can vary and ordering that he should be contacted should any limit be passed. Examples would be: call if the pulse rate goes over 110, or if temperature exceeds 101, or if blood pressure drops below 100.

Defendant's Case

The defense attempted to show dramatic differences between practices in Mississippi and Cleveland, Ohio. In the words of the court, the surgeon was less than complimentary of the nursing staff at the hospital where he had been practicing for 16 years. The surgeon testified that he was assisted by nurses who were on duty at the time and that he had no option in their selection, had no way of knowing their qualifications, but assumed they were competent because they were selected by the hospital for duty in the surgical ward.

The Court's Decision

The court did not find the surgeon guilty of negligence. Rather the court reversed the exclusion of testimony by experts from Cleveland and remanded the case for a new trial. The court noted that the evidence of differences between Cleveland and the Mississippi community were related to facilities and resources as opposed to any qualitative differences in postoperative care prescribed. The only relevant difference which the court found from the evidence was a possible difference in the general quality and competence of nursing personnel. However, the court reasoned that this difference increased the surgeon's own responsibility:

> The record reflects that [the doctor] had been practicing in [the hospital] for approximately 16 years and that he was thoroughly familiar with the capabilities of the nursing staff, and the limitations thereon.
>
> By establishing the inadequacy of the nursing and personnel resources available to him [the doctor] only increases his own responsibility. Where a physician is working with medical personnel of known modest competence, his duty of instruction and control is increased. That [the doctor] may have had doubts about the quality of nursing care at [the hospital] lends considerable credibility to the expert testimony to the effect that far more specific postoperative orders or instructions should have been provided.

Unanswered Questions

In the course of its analysis the court set forth these propositions:

(1) Each physician has a non-delegable duty to render professional services consistent with an objectively ascertained minimum level of competence relevant to the particular case.
(2) This duty includes the entire caring process including follow-up and after care.
(3) The content of the duty must "take into consideration the quality and kind of facilities, services, equipment, and other resources available."

It is the last of these three propositions that raises questions whenever the needed specialized services and equipment are not available locally but are reasonably accessible in major centers. As part of this third duty the physician must consider these factors:

- time (is there an emergency?)
- risk (will transfer to an appropriate facility involve substantial risk?)
- economics (are transferee facilities sufficiently superior to justify the trouble and cost?)

Conclusion

In medical malpractice cases in Mississippi expert testimony concerning norms of national standards of practice may be presented by experts drawn from anywhere in the U.S. provided the testimony is based on information reasonably available to the treating physician. Once these experts are informed of the local facilities (whether by visitation, listening to other witnesses, or by hypothetical question), national experts may express opinions as to the care and duty of the defendant and whether the acts or omission of the defendant resulted in compliance with the duty.

The physician has a duty to evaluate services and equipment not available locally, but reasonably accessible in major centers, against factors of time, risk, and economics. While the court has imposed this duty, it indicated that discussion of these factors must await proper cases. ★★★

Drawer EF (39762-5288)

Reference

1. _____ 466 So. 2nd 856 (Miss. 1985).



The President Speaking

Marry a Pharmacist's Daughter

Ralph L. Brock, M.D.
McComb, Mississippi

Recently I sat in on a discussion with representatives of the pharmacy profession. I listened to the long-standing problems they have getting specific instructions from the physician concerning prescription refills and how long to continue to honor a prescription. These are problems that have been a minor problem in my practice over the years, and it occurred to me that I had married into a family of pharmacists and before I finished medical school I had heard their complaints and problems with prescriptions and doctors' instructions. From the very first prescription I wrote, I saw to it that the pharmacist should have no complaints about the way I wrote mine.

I suggested in this committee meeting that day that we could get the problems solved by having the physicians marry a pharmacist's daughter. I was being facetious but there should be some lessons that can be learned from the habits I formed early and have helped me for the past 38 years.

The pharmacist is a very important link in the health care chain. They can be extremely helpful to us and to our patients, but they are at a distinct disadvantage if we don't let them know exactly what we want. It should go without saying that the medicine name, strength, amount, and dosage instructions should be accurate. If the age of the patient could change dosage requirements, this should be included. Particular care should be taken if the dosage ordered is the least bit unusual.

The number of refills should be clearly indicated. If this is not included the pharmacist has to call you or make the decision, and this may go against what you have in mind for this particular patient. I like for all my prescriptions to expire in six months and this is printed on each one. The importance of this was brought to my attention in a dramatic way in 1972 when new laws came out concerning certain drugs that required a new prescription after six months. I started getting calls from both patients and pharmacists to authorize new prescriptions for medicine that were being refilled from my father's prescriptions, and he had been dead for eight years!

It may happen tomorrow, but to my knowledge, I have never had any prescriptions stolen or forged. I give credit to decisions

(Continued on page 82)

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XXVII Number 3

March 1986

Litigiousness a Sign of Social Decay

Never before in recorded history have a people enjoyed such an affluent life as we in these United States. Even the poorest suffer little and the percentage of these is quite small.

We have enjoyed more leisure time, fewer work hours, better protection from bodily harm and have been afforded freedom of speech, worship and the right to the pursuit of happiness.

However, daily signs of decay become more evident: the breaking-up of the family unit, the government subsidizing illegitimacy, the gradual loss of the work ethic and the disintegration of pride in our country.

The cloud of the atomic bomb hangs over our head. We see the destruction of our forests and wildlife, due to man's carelessness and greed.

We see the deterioration of our democracy by man's voting himself largess at the expense of others. The elderly become a greater burden to society as the medical profession keeps them alive far beyond any quality of life.

In media events great discussion occurs in explaining Reagan's popularity. The most cite his macho personality, his acting ability, his persuasiveness with congress — but I believe it is because he advocates the things that have made this country great, i.e. fiscal sanity, honesty in government, pride in our country, return of the work ethic and the integrity of the family.

The so called "silent majority" still believe in these values and still see Reagan as a leader who can restore these at least in part.

One example of this decay in society is the litigiousness that has become so widespread. It not only pertains to malpractice but to all areas of society. The "something for nothing" attitude that so permeates our country is a prime example of this deterioration of moral fiber.

The medical community is not without fault. We haven't properly policed our ranks. We are guilty of selfishness and greed. But we certainly don't deserve the image some lawyers try to picture us.

With a lawyer for each 600 people now and at the present rate of increase one for every 300 by the mid-nineties there is no end to the time doctors will have to devote to defend themselves in court or what they will have to pay for liability insurance.

The one thing we can do and must do is to get legislation passed to limit the amount for pain and suffering. It has been accomplished in California. It will be accomplished elsewhere and it can be done here if we all help!

W. Moncure Dabney, M.D.
Editor Emeritus

Medico-Legal Brief

No Restraint of Trade By Hospital that Denied Podiatrists Staff Privileges

A restraint of trade action by podiatrists against a hospital and several individual physicians should be dismissed, a federal trial court in North Carolina ruled.

The podiatrists applied for staff privileges at a public hospital. The hospital bylaws permitted staff privileges only for physicians and dentists. The hospital declined to amend its bylaws to grant privileges to the podiatrists.

The podiatrists filed suit claiming that the hospital and the individual physicians engaged in a group boycott to deny them staff privileges. The hospital contended that its actions were based on the good faith judgment that high quality care required that surgery performed at the hospital only be performed

by physicians educated and trained to treat the whole person.

Granting summary judgment in favor of the hospital and individual physicians, the federal trial court said that the hospital's refusal to change its bylaws and refusal to grant staff privileges to the podiatrists were not illegal concerted actions resulting in a boycott. The court said the actions were undertaken in good faith in response to the hospital's duty to insure that it would provide quality patient care. — *Cooper v. Forsyth County Hospital Authority, Inc.*, 604 F.Supp. 685 (D.C., N.C., March 14, 1985)

COMMENT

Termination of Pregnancy

The decision to have an abortion is a personal one. Only the individual who is pregnant should determine what is best for her. For many impressive reasons, women find their life situation to be extremely incompatible with nine months of pregnancy, delivery of a baby, and responsibility of child care for 18 years. Most women find the prospect of adoption unbearable (95% of teenagers who deliver a baby decide to keep it). Adoption is anything but the panacea that anti-choice people would have one believe.

Tactics of some anti-choice people have become unlawful and deplorable. Some fanatics are doing everything within their power to impose their will on others who do not share their views. Unfortunately, some zealots have even resorted to violence.

Fraudulent advertising by deceitful anti-choice people is the most contemptible scheme, and even suggestive of misogyny. The scenario is as follows: "Crisis Pregnancy Center" will advertise support or help similar to this — "Unwanted pregnancy?? Need help?? Free pregnancy test and free counseling available. Call _____."

Most teenagers who respond to this ad want information pertinent to abortion. Instead of receiving accurate, factual information (given in a physician's office), she is shown biased, gruesome photographs, video tapes, etc. of propaganda. The ad leads one to believe supportive counseling relevant to unwanted pregnancy is available. However, these anti-choice people actually capitalize on the patient's feeling of guilt, or they create guilt to recruit these young naive women into their campaign to outlaw all abortions. Guilt is inflicted when compassion is needed.

The worst side effect of this chicanery is a delayed decision resulting in an advanced abortion with a much higher mortality rate, as the following figures illustrate.

Abortion before 9 weeks	1 in 400,000
Abortion from 9-12 weeks	1 in 100,000
Abortion from 13-16 weeks	1 in 25,000
Abortion after 16 weeks	1 in 10,000
Continuation of pregnancy	1 in 10,000
Illegal Abortion	1 in 3,000

When abortion was illegal, a physician would not risk loss of his or her medical license and/or imprisonment by performing an abortion. Therefore, women had to risk their lives and future fertility to have an abortion performed by unqualified, nonprofessional persons under clandestine circumstances.

Because abortion is now legal, a woman can have a safe abortion performed by a specialist in gynecology using sterile technique for a nominal fee.

An accidental conception should not mean forced motherhood. Most abortion patients are teenagers in school or young women in college pursuing an education or a career goal who realize that continuing a pregnancy to delivery could ruin their future.

Why do these anti-choice people have more empathy for products of conception than for the pregnant woman? In my opinion, the rights of the woman bearer have priority over the products of conception.

The present law is fair. Freedom of choice should be maintained. It should not be taken away by people who are against abortion. No one is forcing any woman to have an abortion. Likewise, no woman should be forced to deliver an unwanted baby resulting from an accidental conception. Responsible parenthood demands that we bring up our children with opportunities for a good education and in an environment conducive to self worth and success.

I hope this information will make everyone realize the serious distress women will suffer if the Supreme Court decision which legalized abortion in 1973 is reversed. A ban on abortion will affect virtually all women between the age of 12 through 50.

Tom Gunter, M.D.
Columbus, MS

MSMA HMO/IPA Reaches Initial Capitalization Goal

Continued development of the MSMA's HMO/IPA was assured February 28, the deadline for initial stock purchases. Well over the required 700 members participated in the first phase of the capitalization process for the Mississippi Physicians Health Insurance Company (HMO) and the Mississippi Physicians Practice Association (IPA).

The companies will now proceed with their organizational activities to include staffing and developing a product to be marketed to interested parties.

The Mississippi Physicians Health Insurance Company was chartered on December 6, 1985 as a Mississippi stock insurance company, and the Mississippi Physicians Practice Association was organized as a non-profit membership corporation and incorporated on December 4, 1985.

MSMA members were offered an opportunity to join the two organizations in a letter mailed to all members on December 23, 1985. February 28, 1986 was the deadline for purchasing stock in the Mississippi Physicians Health Insurance Company and joining the Mississippi Physicians Practice Association at cost of $2,000 and $500 respectively. On March 1, 1986, the cost rose to $2,500 and $750 respectively. After June 1, 1986, cost will increase to $3,000 and $1,000.

UMC Announces Faculty Appointments

Ten have been named to the faculty of the University of Mississippi Medical Center in medical, health related professions and centerwide appointments for the current academic session.

The appointments were announced, following approval by the Board of Trustees of State Institutions of Higher Learning, by Dr. Norman C. Nelson, vice chancellor for health affairs.

Appointed in the School of Medicine were Dr. L. Susan Buttross, instructor in pediatrics (child development); Dr. Pramoda K. Devabhaktuni, instructor in medicine; Dr. Rae R. Hanson, assistant professor of pediatrics (neurology) and assistant professor of neurology; and Dr. Carol E. Scott-Connor, associate professor of surgery.

Dr. Jean-Pierre Montani was named assistant professor of physiology and biophysics on the centerwide faculty.

The School of Health Related Professions named Barbara H. Connolly, associate professor of physical therapy; Pamela Fowler, instructor in emergency medical technology; Winston E. Jones, instructor in emergency medical technology; Deborah M. Roebuck, instructor in emergency medical technology; and Mary K. Triggs, instructor in nurse anesthesiology.

Dr. Buttross, a 1972 graduate of Mississippi State University, earned the M.D. degree in 1977 at UMC, where she completed her residency in 1979. She also did a residency at the University of Texas Medical Branch at Galveston, and in 1981, began private practice in Texas City, Texas. In 1982, she joined the staff of Health America in San Antonio, Texas, as a pediatrician and has been a staff physician there since 1984.

Dr. Devabhaktuni earned the B.Sc. in 1974 at Delhi University, and the M.B.B.S. in 1979 at Lady Hardinge Medical College at the University of Delhi. She completed a residency in 1981 at Willingdon Hospital, and a fellowship in 1982 at the University of Alabama. She has been a resident at the University Medical Center since 1985.

Dr. Hanson earned the B.S. in 1973 and the M.D. in 1976 at the University of Arizona. He did his internship in 1977 at the William Beaumont Army Medical Center at El Paso, Texas, and completed a residency in 1980, and a fellowship in 1983, at Walter Reed Army Medical Center. From 1977-1979, he served as a battalion flight surgeon in the U.S. Army Medical Corps, and as chief of the child neurology service and assistant chief of neurology service at William Beaumont Army Medical Center since 1983.

Dr. Scott-Conner, who earned the B.S. in 1969 at the Massachusetts Institute of Technology and the M.D. in 1976 at New York University, completed an internship in 1977 and residency in 1981 at New York University Medical Center where she was clinical instructor in surgery from 1980-1981. She was assistant professor of surgery from 1981-1985, and she was named associate professor of surgery before coming to UMC.

Dr. Montani, who has been visiting assistant pro-

(Continued on page 83)

UMC Faculty Member Retires



Dr. William B. Wiener, center left, was honored at a Jackson Country Club reception hosted by faculty members in the obstetrics and gynecology department of the University of Mississippi Medical Center on the occasion of Dr. Wiener's retirement from the ob-gyn faculty. Also present for the occasion were Dr. Woodard Beecham, center right, Dr. Wiener's teacher at Tulane University, and Dr. Wiener's classmates at Tulane, Dr. T. G. (Tommy) Ross, left, and Dr. James Royals, both of Jackson.

POSTGRADUATE CALENDAR

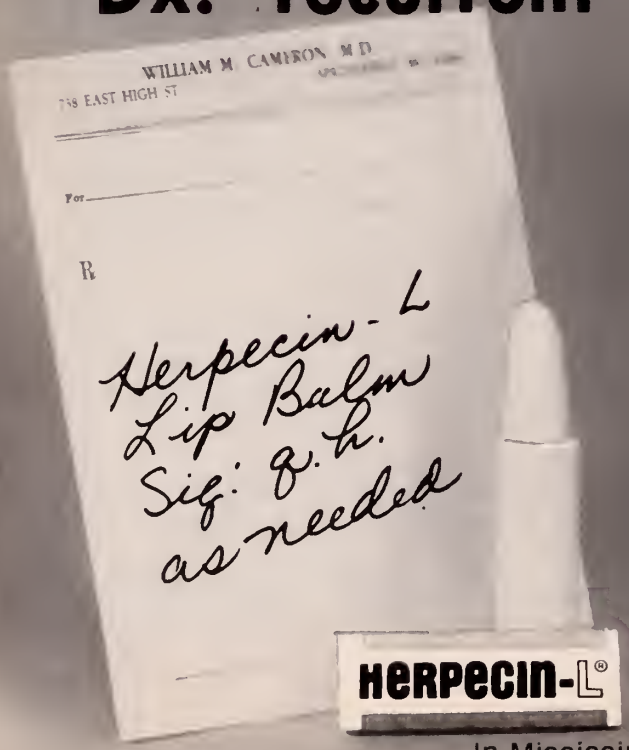
March 24-26
JOINT CONFERENCE ON AGING
Royal D'Iberville Hotel, Biloxi

April 5
SEVENTH ANNUAL SPRING SONIC SYMPOSIUM
Ramada Renaissance Hotel, Jackson

April 9-12
1986 FAMILY PRACTICE UPDATE
Ramada Renaissance Hotel, Jackson

April 19
NUCLEAR MEDICINE UPDATE
MISSISSIPPI SOCIETY OF NUCLEAR MEDICINE NINTH ANNUAL MEETING
University Medical Center, Jackson

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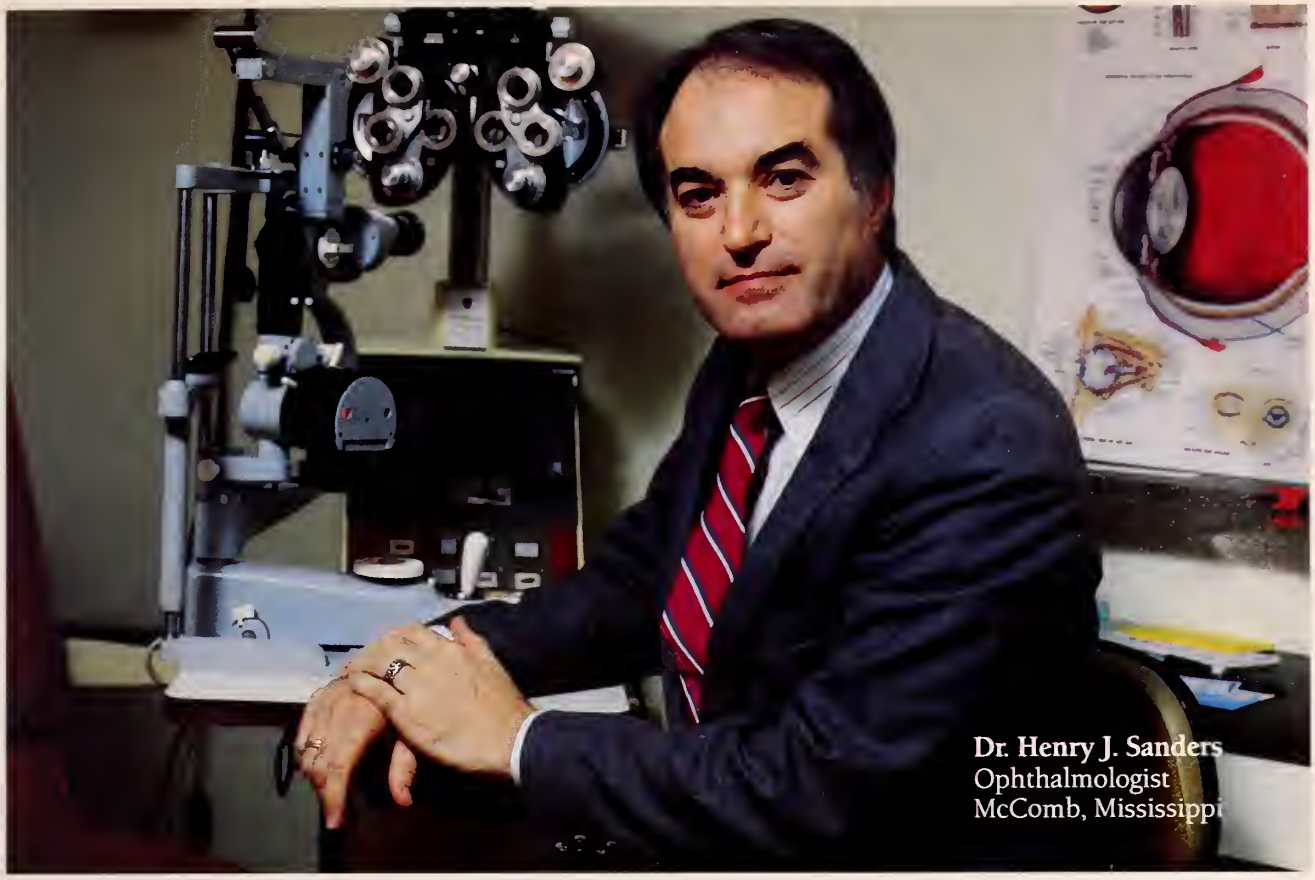
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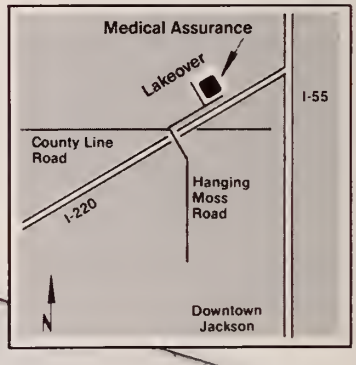
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NEW MEMBERS

ALEXANDER, RICHMOND L., III, Meridian. Born Big Springs, TX, April 10, 1955; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned and medicine residency, Baylor, Dallas, TX, fellowship in pulmonary diseases, University of Arkansas, Little Rock, 1983-85; elected by East Mississippi Medical Society.

ALLEN, PAUL M., Pascagoula. Born Providence, RI, May 6, 1942; M.D., University of Pennsylvania School of Medicine, Philadelphia, 1967; interned U.S. Public Health Service Hospital, New Orleans, 1967-68; ob-gyn residency, Charity Hospital, New Orleans, 1968-71; elected by Singing River Medical Society.

BARR, WILLIAM MICHAEL, Clarksdale. Born Christopher, IL, Feb. 26, 1954; M.D., University of Illinois School of Medicine, Chicago, 1980; interned and orthopedic surgery residency, Richland Memorial Hospital, Columbia, SC 1980-85; elected by Clarksdale and Six Counties Medical Society.

BLOUNT, JUNE G., Jackson. Born Chicago, May 31, 1924; M.D., University of Mississippi School of Medicine, Jackson, 1965; interned, one year, Mississippi Baptist Medical Center, Jackson; radiology residency, University Medical Center, Jackson, 1966-69; elected by Central Medical Society.

BROWN, J. ARTHUR, Aberdeen. Born Monroe County, MS, Aug. 8, 1955; M.D., University of Mississippi School of Medicine, Jackson, 1982; interned and family practice residency, Baptist Medical Center, Gadsden, AL, 1982-85; elected by Northeast Mississippi Medical Society.

BUCKLEY, NEAL W., Jackson. Born Jackson, MS, Sept. 29, 1955; M.D., University of Mississippi School of Medicine, Jackson, 1984; interned, one year, University Medical Center, Jackson; elected by Central Medical Society.

BYDALEK, MARTIN B., Pascagoula. Born Shelbyville, TN, Feb. 12, 1952; M.D., University of Tennessee Center for Health Sciences, Memphis, 1982; interned, one year, General Hospital, Louisville, KY; emergency medicine residency, University of Louisville, Louisville, 1983-85; elected by Singing River Medical Society.

CALHOUN, LAURIE L., Pascagoula. Born Moss Point, MS, Feb. 17, 1954; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned Medical College of Virginia, Richmond, one year; pediatric residency, University of South Alabama, Mobile, 1980-82; fellowship in neonatology, University Medical Center, Jackson, MS, 1982-84; elected by Singing River Medical Society.

CLARK, ALAN J., Pascagoula. Born Malden, MA, Nov. 24, 1946; M.D., Yale University School of Medicine, New Haven, CT, 1972; interned Maine Medical Center, Portland, 1972-73; ophthalmology residency, Albany Medical Center, Albany, NY, 1973-76; elected by Singing River Medical Society.

DAVIS, NANCY L., Oxford. Born Middlesboro, KY, July 27, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1981; interned Methodist Hospital, Memphis, one year; radiology residency, same, 1982-85; elected by North Mississippi Medical Society.

DEDEAUX, SIDNEY J., Morton. Born New Albany, MS, Oct. 11, 1940; D.O., West Virginia School of Osteopathic Medicine, Lewisburg, 1984; interned Doctors Hospital, Tucker, GA, one year; elected by Central Medical Society.

ELLIS, TERRY K., Biloxi. Born Biloxi, MS, Dec. 9, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned and emergency medicine residency, Pensacola Educational Program, Pensacola, FL, 1977-80; elected by Coast Counties Medical Society.

ENDE, MAURICE J., Corinth. Born Houston, TX, Jan. 10, 1946; M.D., University of Texas Medical School of Medicine, San Antonio, 1977; interned De Paul Hospital, Norfolk, VA, one year; radiology residency, Mt. Sinai Hospital, NY, 1978-81; elected by Northeast Mississippi Medical Society.

EYRICH, GEORGE A., Meridian. Born Natchez, MS, Feb. 15, 1955; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned, internal medicine residency and cardiology residency, University Medical Center, Jackson, 1980-85; elected by East Mississippi Medical Society.

GOEL, DINESH K., Jackson. Born India, Oct. 9, 1945; M.D. in India in 1967; interned Salem Hospital, Salem, MA, 1971-72; surgery residency, Henry Ford Hospital, Detroit, MI, 1972-73; surgery residency, St. Vincent Hospital, Worcester, MA, 1973-76; elected by Northeast Mississippi Medical Society.

NEW MEMBERS / Continued

GORE, NEY M., III, Picayune. Born Memphis, TN, Oct. 6, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned Wayne State University School of Medicine, Detroit, MI, One year; medicine residency, William Beaumont Army Medical Center, El Paso, TX, 1980-82; elected by Pearl River Medical Society.

GRAHAM, RONALD A., Tupelo. Born Laurel, MS, Jan. 16, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned and orthopedic surgery residency, University Medical Center, Jackson, 1979-84; trauma fellowship, Ulm, West Germany, and Scottish Rite Hospital for Crippled Children, Atlanta; elected by Northeast Mississippi Medical Society.

HARDEY, KIM A., Hattiesburg. Born New Orleans, LA, Oct. 25, 1954; M.D., Louisiana State University School of Medicine, New Orleans, 1981; interned and ob-gyn residency, Charity Hospital, New Orleans, 1981-85; elected by South Mississippi Medical Society.

HENRY, MICHAEL A., Columbus. Born Bossier City, LA, July 22, 1951; M.D., Tulane University School of Medicine, New Orleans, 1979; interned and general surgery residency, Charity Hospital, New Orleans, 1979-84; elected by Prairie Medical Society.

JONES, JAMES S., Jackson. Born Jackson, MS, June 7, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned Baptist Memorial Hospital, Memphis, TN, one year; medicine residency, same, 1980-82; pulmonary medicine residency, University of Tennessee, Memphis, 1982-84; elected by Central Medical Society.

JORANSEN, JAMES A., Jackson. Born Chicago, IL, Sept. 3, 1955; M.D., Baylor College of Medicine, Houston, TX, 1964; interned Ben Taub General, Houston, one year; pediatric residency and fellowship in cardiology, University of Minnesota, Minneapolis, 1978-71; elected by Central Medical Society.

KNUTSON, RICHARD A., Greenville. Born Schenectady, NY, Feb. 10, 1937; M.D., New York Medical College, New York, NY, 1970; interned and general surgery and orthopedic surgery residency, Metropolitan Hospital, New York, NY, 1970-75; elected by Delta Medical Society.

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LEIGH, JOE N., Hattiesburg. Born Philadelphia, MS, Dec. 29, 1956; M.D., University of Mississippi School of Medicine, Jackson, 1982; interned and anesthesiology residency, University of Texas, Galveston, 1982-85; elected by South Mississippi Medical Society.

MARTIN, LAWRENCE M., Biloxi. Born Denton, TX, Dec. 23, 1942; M.D., University of Mississippi School of Medicine, Jackson, 1969; interned University of Wisconsin Hospital, Madison, one year; psychiatry residency, Duke University of Medicine, Durham, NC, 1970-73; elected by Coast Counties Medical Society.

MAY, MICHAEL G., Hattiesburg. Born Laurel, MS, May 21, 1955; M.D., University of Mississippi School of Medicine, Jackson, 1981; interned and family medicine residency, University Medical Center, Jackson, 1981-84; elected by South Mississippi Medical Society.

MURPHY, HARRIET ANN, Gulfport. Born Jersey City, NJ, Oct. 25, 1923; M.D., Louisiana State University School of Medicine, New Orleans, 1946; interned and pediatric residency, Medical Center, Jersey City, NJ, 1946-50; elected by Coast County Medical Society.

PHILLIPS, CLYDE B., Tupelo. Born Butler, AL, March 16, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1978; Orthopedic surgery residency, same, 1978-82; elected by Northeast Mississippi Medical Society.

POWELL, WILLIAM EDWIN, Waynesboro. Born Tupelo, MS, May 7, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1981; interned and family practice residency, University of South Alabama, Mobile, 1981-84; elected by South Mississippi Medical Society.

RUTH, MICHAEL, Laurel. Born Tulsa, OK, Sept. 12, 1948; M.D., Northwestern University Medical School, Chicago, 1975; interned Confederate Memorial Medical Center, Shreveport, LA, one year; residency in medicine and gastroenterology, LSU Medical Center, Shreveport and New Orleans, 1976-80; elected by South Mississippi Medical Society.

SEGARS, KELLY SCOTT, JR., Iuka. Born Nashville, TN, Dec. 6, 1955; M.D., University of Mississippi School of Medicine, Jackson, 1982; interned Baptist Memorial Hospital, Memphis, one year; medicine residency, LDS Hospital, Salt Lake City, Utah, 1983-85; elected by Northeast Mississippi Medical Society.

SHERWOOD, CHARLES G., Jackson. Born Margate, England, March 3, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned and ophthalmology residency, University Medical Center, Jackson, 1978-82; elected by Central Medical Society.

SMITH, DONALD K., Okolona. Born Raleigh, MS, Nov. 21, 1955; D.O., West Virginia School of Osteopathic Medicine, Lewisburg, 1984; interned Sun Coast Hospital, Largo, FL, one year; elected by Northeast Mississippi Medical Society.

STEPHENS, DAVID B., Hattiesburg. Born Trinidad, W. I., April 2, 1942; M.D., Tulane University School of Medicine, New Orleans, 1968; interned Deval Medical Center, Jacksonville, FL, one year; general surgery residency, Vanderbilt University, Nashville, TN, 1971-75; thoracic surgery residency, St. Luke's Hospital-Mid American Heart Institute, Kansas City, MO, 1980-82; elected by South Mississippi Medical Society.

THOMAS, DENNIS R., Pascagoula. Born Ft. Wayne, IN, Oct. 16, 1951; M.D., Indiana University School of Medicine, Indianapolis, 1979; interned Medical University of South Carolina, Charleston, 1979-80; medicine residency, same, 1979-81; fellowship in cardiology, St. Francis Hospital and Medical Center, Hartford, CT, 1981-83; elected by Singing River Medical Society.

THOMPSON, PHIL D., Raleigh. Born Laurel, MS, March 7, 1954; D.O., University of Health Science College of Osteopathic Medicine, Kansas City, MO, 1983; interned Doctors Hospital, Tucker, GA, one year; elected by South Mississippi Medical Society.

WRIGHT, BENNIE B., JR., Cleveland. Born Inverness, MS, March 29, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned and surgery residency, University of Texas, Galveston, 1979-83, and one-year surgery residency, Mt. Carmel Mercy Hospital, MI, 1983-84; elected by Delta Medical Society.

YORK, MILTON R., Greenville. Born Picayune, MS, Aug. 27, 1932; M.D., University of Mississippi School of Medicine, Jackson, 1958; interned and anesthesiology residency, University Medical Center, Jackson, 1958-61; elected by Delta Medical Society.

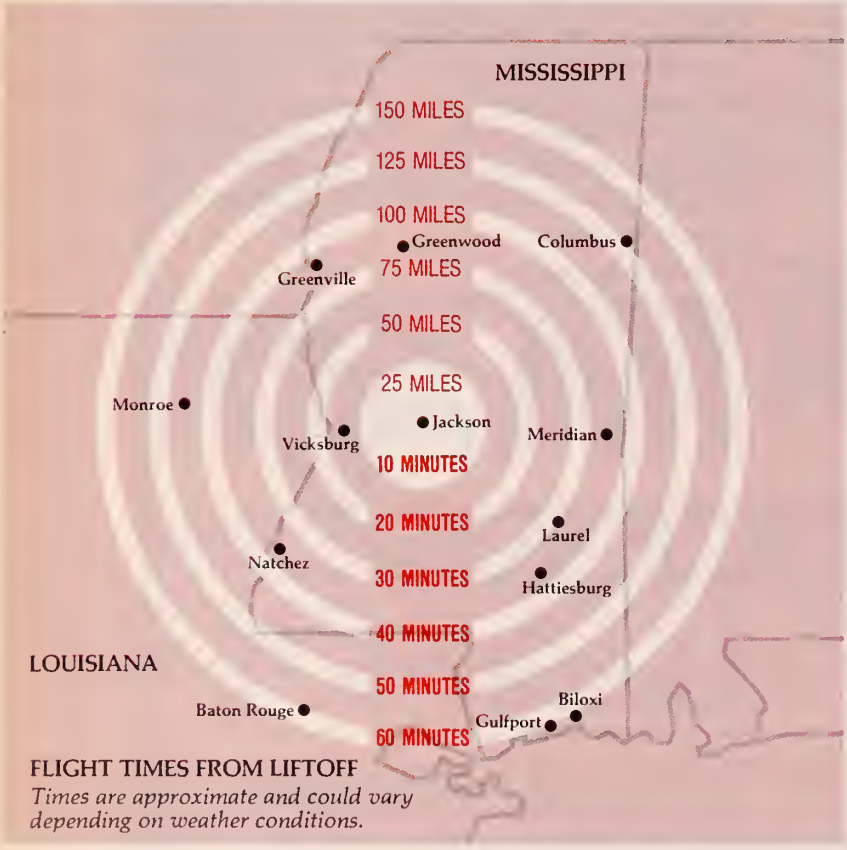
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PERSONALS

JAMES ACHORD of UMC was a seminar participant for a meeting of the Council of Ohio Colleges of Pharmacy in New Orleans and was clinical consultant for the Rorer Group in Philadelphia, Pennsylvania.

WILLIAM BATES of UMC was guest lecturer at a meeting of the Florida Academy of Family Physicians in Jacksonville.

BLAIR BATSON of UMC was examiner for the American Board of Pediatrics in Orange County, California.

CHRIS H. BENSON has associated with JAMES B. PENNEBAKER for the practice of rheumatology at the Hattiesburg Clinic.

BERT C. BRADFORD announces the establishment of the Brookhaven Children's Clinic at 1026 Biglane Drive.

DONALD H. BUTTS of Jackson announces the association of THOMAS E. INGRAM for the practice of neurology at 1815 Hospital Drive, Suite 262.

C. RON CANNON of Jackson has been named an "Outstanding Young Man of America, 1985."

DONALD V. CONERLY of Hattiesburg recently was certified by the American Board of Family Practice.

EVERETT H. CRAWFORD of Tylertown announces his retirement from the practice of medicine.

C. RALPH DANIEL, III of Jackson spoke at the annual meeting of the American Academy of Dermatology. He also was editor for a recently published book on nail disorders.

SAM FILLICNGANE has established offices for the practice of osteopathic medicine at Franklin County Medical Arts Building in Meadville and at the Roxie Clinic.

OWEN EVANS of UMC was guest lecturer at the Norfolk General Hospital and Portsmouth Naval Hospital in Norfolk, Virginia.

CLAUDE EARL FOX of Jackson has been appointed State Health Officer for the Alabama State Department of Health.

'RODNEY E. FROTHINGHAM of Greenville has been selected to serve as physician representative with the Curriculum Review Board of the American Association of Medical Assistants.

T. ERIC HALE of Hattiesburg recently received certification by the American Board of Family Practice.

JAMES HARDY of UMC was visiting professor at the University of Tennessee Health Sciences Center in Memphis.

JULIAN HENDERSON of Jackson has been elected chief of the medical staff at Hinds General Hospital.

JACK C. HOOVER of Pascagoula was speaker for a Community Education program on birth defects.

DAVID H. IRWIN, JR. has associated with Internal Medical Associates of Tupelo for the practice of cardiology.

JOHN JACKSON of UMC chaired the genetics section of the Southern Society for Clinical Investigation which met in New Orleans.

KENT KIRCHNER of UMC made a presentation at the annual meeting in New Orleans of the Southern Society for Clinical Investigation.

Vicksburg Mayor Demery Grubbs presented CECIL KNOX with the Distinguished Service Award at a reception honoring Dr. Knox upon his retirement.

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PERSONALS / Continued

MATTHEW F. KULUZ of Pascagoula was speaker for a Community Health Education program on birth defects.

RAY LYLE of Starkville recently spoke at a meeting of the Starkville Lions Club.

JOHN MORRISON of UMC lectured at McComb, Meridian and Pascagoula recently.

HOWARD NICHOLS of UMC was an examiner for the American Board of Pediatrics in Orange County, California.

WILLIAM NICHOLAS of UMC recently spoke on the subject of diabetes at the seminars sponsored by the Mississippi Department of Vocational Rehabilitation and the University of Southern Mississippi.

RAYMOND OVERSTREET announces the opening of his office for the practice of psychiatry at 501 7th Street North in Columbus.

SESHADRI RAJU of UMC presented a paper at the Southern Association for Vascular Surgery meeting in Puerto Rico and at the International Joint Conference on Stroke and Cerebral Circulation in San Francisco.

CLIFF SEYLER of Pascagoula discussed child discipline at a session sponsored by the Gulf Coast Mothers' Center and the Human Services Department of Jackson County Junior College.

J. ROBERT SHELL of Vicksburg conducted a self-help workshop on breast self-examination.

ARTHUR W. ST. CLAIR of Jackson has retired from the practice of medicine.

DAVID TIMM announces the opening of his office for the practice of pediatric and adolescent medicine at 101 Tracetown in Natchez.

RAUL VALENZUELA of Jackson was a faculty member of the American course of the Pan American Association of Ophthalmologists in Key Biscayne, Florida.

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THE PRESIDENT SPEAKING

(Continued from page 70)

I made about my prescriptions when I first started practice. I chose one color paper and one color ink for the print and have not changed. I decided that I would use my full legal signature on my prescriptions, and I have not changed. I write out all my prescriptions and have never used pre-printed pads. Prescription pads have always been special items at my home and office. We have never used them as scratch pads and the children were never allowed to play with them. Even now, I have full control over my prescription pad supply. I order them, receive the order, store them in a special cabinet and personally distribute them to the different places that I have chosen. I like to have a pad conveniently close to me at all times. I have kept the number of these places to a minimum and I have been able to keep a mental note of how long the supply should last at each location. I have made a special effort to always have my own prescription pad with me. My prescriptions have their own distinct appearance, and any attempt for someone to use a different form with my name would be an immediate flag for the pharmacist to see.

I do not get many calls back from pharmacists, but when I do, I try to thank them for helping protect me and my patient. I hope I have been courteous each time. I guess I still talk to them as if my father-in-law were on the line.

RECOLLECTIONS

Thirty years ago, the March issue of JOURNAL MSMA reported the most recent statistics on health care expenditures. According to the Health Insurance Institute, Americans in 1959 spent $314 billion on their personal needs. Of this total, $18.3 billion, or 5.8 percent, went for recreation, and exactly the same amount was spent on medical care. In addition to the recreation expenditure, Americans spent $9.6 billion on alcoholic beverages and $7.0 billion on tobacco products.

The Institute said there had been sharp changes in the distribution of each dollar spent for medical care in the twenty-year period between 1939 and 1959. From each dollar spent for medical care in 1939, physicians received 30 cents, some 28 cents went for drugs and appliances, 17 cents went to hospitals, 14 cents to dentists, and 11 cents was spent on all other medical needs, including other professional services and nursing home care. In 1959, some 27 cents went to physicians, 26 cents went for drugs and appliances, 30 cents to hospitals, 11 cents to dentists, and six cents for all other medical care.

"The Present Status of Smoking and Cancer of the Lungs" was the title of an article in that issue by Dr. Guy T. Vise of Meridian. An abstract stated: "when history looks back at the 20th century, the great issues of the day will stand out in bold relief. Included will be the conflict of communism and capitalism, the use of atomic energy, and quite possibly, the question of a causal relationship between smoking and lung cancer." Other articles in the 1961 issue were: "Cancer Therapy Combinations: A Case Report" by Dr. Lawrence W. Long of Jackson, and "Cardiac Arrest: Case Report" (of a 14-month-old surgery patient) by Dr. Martin L. Dalton, Jr. of Jackson.

FACULTY APPOINTMENTS

(Continued from page 73)

fessor of physiology and biophysics at UMC since 1982, is a 1970 graduate of College St. Michel in Fribourg, Switzerland. He attended the University Fribourg and the Medical School of Geneva where he received the M.D. in 1977. He was a research assistant in physiology at the Cardiovascular Institute of the University of Fribourg from 1977-1979, and completed a three-year residency at the University Hospital of Geneva before his fellowships with the Swiss National Foundation in Scientific Research (1982-1983) and the Swiss Foundation of Fellowships in Medicine and Biology (1983-1985).

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GENERAL INTERNIST in growing multi-specialty group desires partner. Medium sized city in Mississippi. Excellent practice opportunity. Contact Charles D. Cannon, Jr., M.D. at (601) 649-2863.

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The Mississippi Disability Determination Services now has a program available for medical society meetings and hospital staff meetings. The purpose of this program is to explain how the disability determination process works, its historical background, its basis in legality and its documentation requirements. Any group interested in this presentation should also contact the Medical Relations Office.

GENERAL SURGEON — Board certified or Board eligible general surgeon needed by progressive, small town in Northeast Mississippi. On Tenn-Tom Waterway; hunting, fishing, water sports. Nearby medical centers. Contact Administrator, P.O. Box 747, Aberdeen, MS 39730; telephone (601)369-2455.

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PEDIATRICIAN to join four man pediatric department in multispecialty group. Excellent salary and benefits leading to full partnership. Contact Jimmy E. Isbell, M.D., Rush Medical Group, P.A., 1800 12th St., Meridian, MS 39301 or call (601) 483-0011.

EMERGENCY ROOM physician needed to staff recently expanded emergency room coverage. Salary negotiable. Small town. 44-bed hospital approved for federal programs, located in central Mississippi. Contact Paul W. Strode, Box 428, Forest, MS 39074.

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Disability Determination Service 84

Forrest General Hospital **4**

Harreld Chevrolet 78

Knoll Pharmaceuticals 68B, 68C, 68D

Eli Lilly and Company 68A
Louisiana Lithotripter 83

Medical Assurance Co. of Miss. 76
Mississippi Baptist Medical Center 80
MSMA Benefit Plan ..... second cover

Premier Printing 81

Roche Laboratories ..... third, fourth covers

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MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 15-19, 1986, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

State and Local

Mississippi State Medical Association, 118th Annual Session, June 4-8, 1986, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, June 25-28, 1986, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, February, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, January, May, and November. H. S. Barrett, Secy., P.O. Box 1810, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington, Yazoo.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, Secy., Mail: Ms. Jenkins, P.O. Box 4053, Meridian 39305. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, Meetings scheduled quarterly. Fred G. Emrich, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, January. Charles S. Watras, 612 Summit St., Winona 38967. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, September, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Steve Parvin, Secy., 106 Strange Rd., Starkville 39759. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 1st Wednesday, February, April, June, August, October, December. John J. McCloskey, Secy., 3003 Short Cut Rd., Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. George R. Bush, Secy., 307 S. 13th Ave., Laurel 39440. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

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735 Riverside Drive
Jackson, MS 39216

Mississippi Chapter
American College of Surgeons
Box 5229
Jackson, MS 39216

North Mississippi Medical Center
830 Gloster Avenue
Tupelo, MS 38801

North Panola County Hospital
Drawer 160
Sardis, MS 38666

Forrest General Hospital
Box 1897
Hattiesburg, MS 39401

Singing River Hospital
P.O. Box 112
Pascagoula, MS 39567

Mississippi Baptist Hospital
1225 N. State Street
Jackson, MS 39201

Magnolia Hospital
Alcorn Drive
Corinth, MS 38834

Gulf Coast Community Hospital
4642 W. Beach Boulevard
Biloxi, MS 39531

Greenwood Leflore Hospital
1508 Leflore Avenue
Greenwood, MS 38930

Jefferson Davis Memorial Hospital
Box 1488
Natchez, MS 39120

Gulfport Memorial Hospital
4500 13th Street
Gulfport, MS 39501

King's Daughter Hospital
Box 948
Brookhaven, MS 39601

Oxford-Lafayette County Hospital
P.O. Box 946
Oxford, MS 38655

Riverside Hospital
Lakeland Drive
Jackson, MS 39208

Biloxi Regional Medical Center
1559 Lafayette St.
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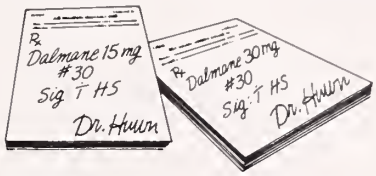
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References: 1. Kales J, *et al Clin Pharmacol Ther 12* 691-697, Jul-Aug 1971 **2.** Kales A, *et al: Clin Pharmacol Ther 18* 356-363, Sep 1975. **3.** Kales A, *et al Clin Pharmacol Ther 19* 576-583, May 1976 **4.** Kales A, *et al Clin Pharmacol Ther 32*:781-788, Dec 1982 **5.** Frost JD Jr, DeLucchi MR. *J Am Geriatr Soc 27*:541-546, Dec 1979 **6.** Dement WC, *et al: Behav Med*, pp. 25-31, Oct 1978. **7.** Kales A, Kales JD *J Clin Psychopharmacol 3* 140-150, Apr 1983 **8.** Tennant FS, *et al:* Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984 **9.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*.355-361, Mar 1977.



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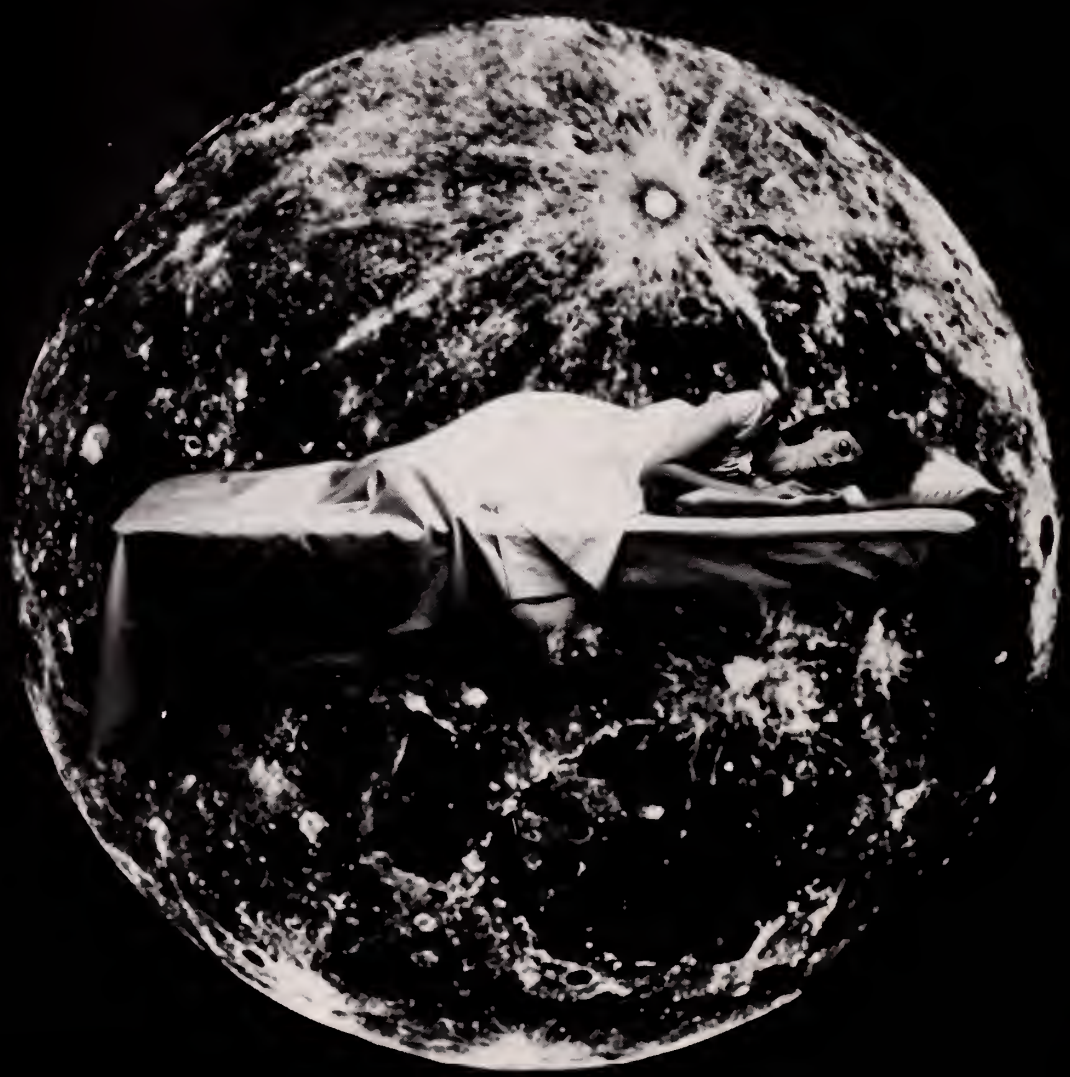
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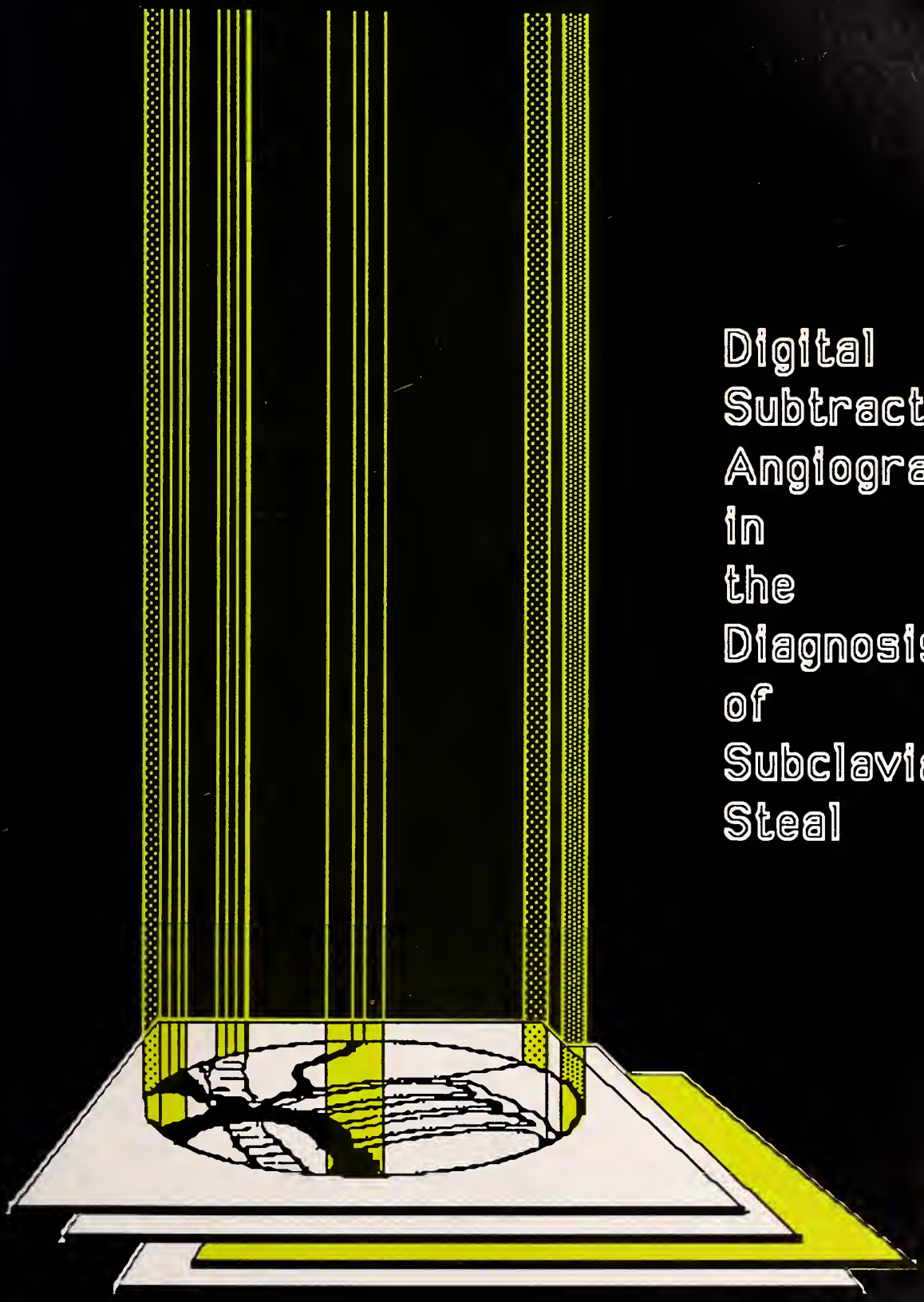


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JOURNAL of the MISSISSIPPI State Medical Association



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The Journal of the Mississippi State Medical Association is owned and published monthly by the Mississippi State Medical Association, founded 1856, at 735 Riverside Drive, Jackson, Mississippi 39202. Subscription rate, $25.00 per annum; $35.00 per annum for foreign subscriptions; $2.25 per copy, as available. Advertising rates furnished on request. Printed by The Ovid Bell Press, Inc., Fulton, Missouri. Second-class postage paid at Jackson, Mississippi, and at additional mailing offices. POSTMASTER: Send address changes to Mississippi State Medical Association, 735 Riverside Drive, Jackson, Mississippi 39202.

CONTENTS

ORIGINAL PAPERS

Dirofilaria Immitis as a Cause of Solitary Pulmonary Nodule — **85** Robert D. Holbert, M.D., William Thomas Robinson, M.D., and Lyman D. Scripter, M.D.

Radiological Seminar CCXLIV: Digital Subtraction Angiography in the Diagnosis of Subclavian Steal — **89** James U. Morano, M.D., James L. Burkhalter, M.D., and Charles J. Brdlik, M.D.

SPECIAL ARTICLE

Statement on Granting Hospital Privileges to Perform Gastrointestinal Endoscopy — **98** Billy W. Long, M.D. and James E. Spence, M.D.

EDITORIAL

Thank You, Dr. Long — **101** Myron W. Lockey, M.D.

THIS MONTH

Grand-Slam Homer — **100** The President Speaking
The Breaking of a Surgeon — **102** Comment
105 Medical Organization
109 Personals
104 Medico-Legal Brief

This month's cover illustration, designed by Bill Tyler of Jackson, was drawn on an Apple Macintosh.

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(ISSN 0026-6396)

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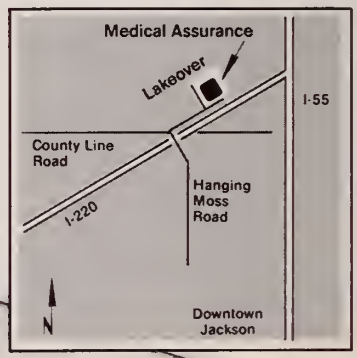
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NEWSLETTER

April 1986

Dear Doctor:

The President's task force on tort reform has recommended a $100,000 cap on non-economic jury awards and reductions in attorney fees of 50% or more. The report also recommends provisions for periodic payments for economic damages and recommends elimination of the collateral source rule.

> Additionally, the task force urges rejection of liability findings "based on fringe scientific or medical opinions well outside the mainstream of accepted scientific or medical beliefs." States are reporting mixed success in getting tort reform bills through legislatures.

States face strict deadlines for setting up their own facilities for disposal of low-level radioactive wastes, under a law signed by President Reagan. The law also makes states liable for damages incurred by businesses forced to shut down because of lack of state provisions for disposal of items such as contaminated clothing and isotopes used in medical diagnosis and equipment. Until now three states -- South Carolina, Washington, and Nevada -- have accepted all the nation's civilian low-level nuclear waste.

The AMA has joined more than 20 other organizations including the American Association of Retired Persons, the American Hospital Association, American Nurses Association and the Federation of American Health Systems, to ask Congress to reject arbitrary cuts in federal health programs. The coalition also is urging Congress to set "reasonable targets" for health programs in the 1987 budget. Medicare cuts have amounted to nearly $40 billion in the past five years, representing 12% of total budget cuts. The group said proposed additional cuts in Medicare and Medicaid "would adversely impact the quality of services and access to needed health care by elderly and poor patients."

William Roberts, former MSMA assistant executive director and legal counsel, has been named the AMA's Washington legislative counsel. Roberts has been serving as director of the Department of State Relations of the AMA's Division of Medical Society Relations.

Sincerely,

Patsy Silver

Patsy Silver
Managing Editor

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DATELINE

MD is Reagan's Choice For HCFA Appointment

Washington, DC - President Reagan announced that he will nominate William L. Roper, M.D. to be administrator of the Health Care Financing Administration (HCFA). Currently Dr. Roper serves as special presidential assistant for health policy. He has chaired an Administration task force that studied physician reimbursement reforms and is now heading a task force on professional liability.

"Test Tube" Baby Is First for UMC Program

Jackson, MS - The state's first "test tube" baby, a healthy, full term girl, was born March 18. The birth is the first for the in vitro fertilization program at University Medical Center, which began in 1983. Parents of the child requested anonymity. Currently two other women in the program are pregnant with births expected in early June and late September.

MSMA HMO/IPA Proceeds With Organization

Jackson, MS - Boards of directors for MSMA's HMO/IPA are in the process of selecting a management plan. The programs exceeded initial capitalization goals on February 28, the deadline for the first phase of development. On March 1 the cost for participation for MSMA members increased to $2,500 for the HMO and $750 for the IPA. After June 1 the cost will increase to $3,000 and $1,000 respectively.

Feeding Withdrawal Not Necessarily Unethical

Chicago, IL - Withdrawal of artificial feeding and hydration for permanently comatose patients is not unethical, provided certain safeguards are present, said a clarifying statement of the AMA's Council on Ethical and Judicial Affairs, following a conference on ethics last month. The Council's opinion adds that physicians should consider prior expressed wishes of the patient and the attitudes of the family.

Relative Value Scale Study Funded by HHS

Washington, DC - Nominee for undersecretary of the Department of Health and Human Services has pledged that HHS will fund the relative value scale (RVS) study being undertaken by Harvard University and the AMA for the three-year term agreed to previously. The intent of the study is to develop a new scale of relative values of various medical procedures to be used to reassess Medicare payment levels.



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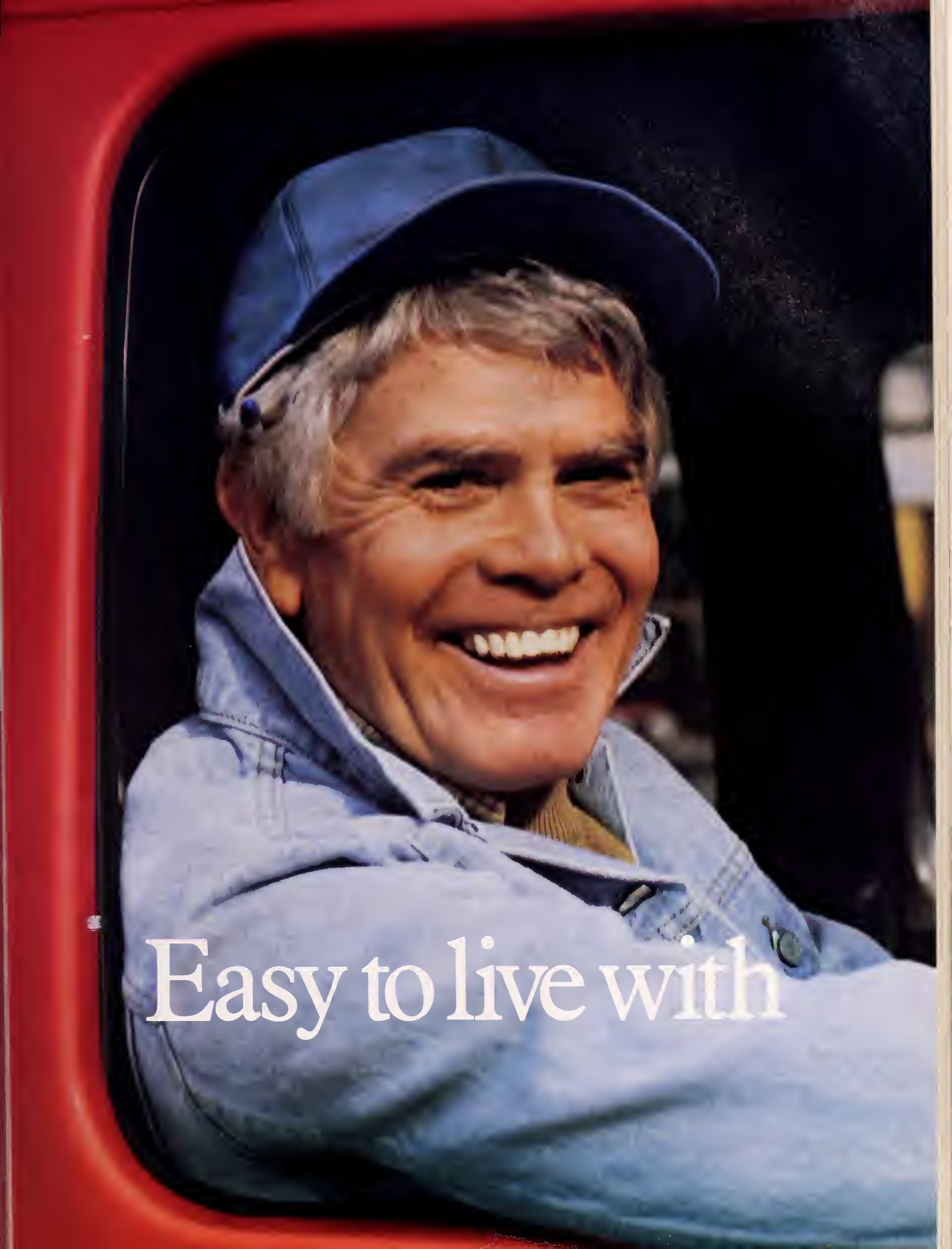
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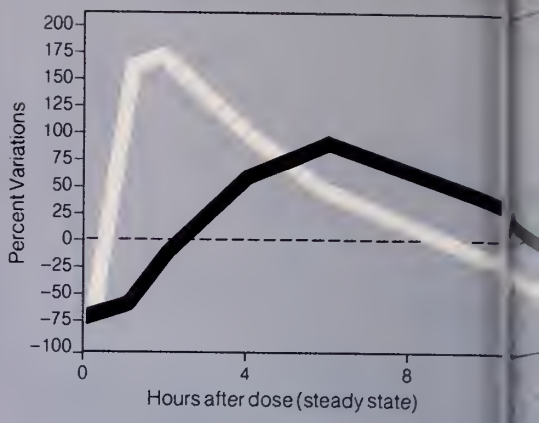
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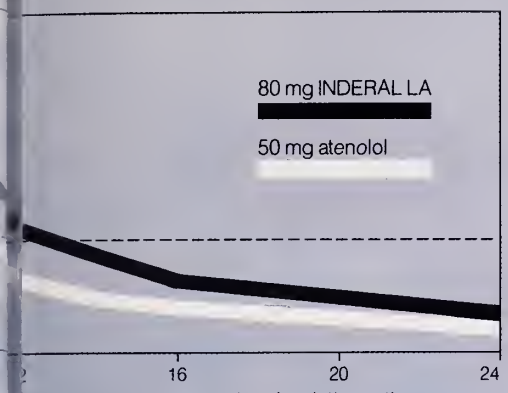
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CONTRAINDICATIONS

Propranolol hydrochloride (INDERAL® LA): Propranolol is contraindicated in: 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol.

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS

Propranolol hydrochloride (INDERAL® LA): CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated, and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or propranolol should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction following *abrupt* discontinuance of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution, since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS

Propranolol hydrochloride (INDERAL® LA): GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. Propranolol is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that propranolol may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs, such as reserpine, should be closely observed if propranolol is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies, in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose. There are no adequate and well-controlled studies in pregnant women. Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: Propranolol is excreted in human milk. Caution should be exercised when propranolol is administered to a nursing mother.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

Hydrochlorothiazide: GENERAL: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely: Hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs irrespective of cause are: Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect of digitalis (eg, increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content.

Any chloride deficit is generally mild and usually does not require specific treatment, except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism, such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

DRUG INTERACTIONS: Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

PREGNANCY: Pregnancy Category C. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnancy requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

NURSING MOTHERS: Thiazides appear in human milk. If use of the drug is deemed essential, the patient should stop nursing.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL® LA): Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations, an acute reversible syndrome characterized by disorientation for time and place; short-term memory loss; emotional lability; slightly clouded sensorium; and decreased performance on neuropsychometrics.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation; mesenteric arterial thrombosis; ischemic colitis.

Allergic: Pharyngitis and agranulocytosis; erythematous rash; fever combined with aching and sore throat; laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia; LE-like reactions; psoriasiform rashes, dry eyes; male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

Hydrochlorothiazide:

Gastrointestinal: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation; jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis.

Central Nervous System: Dizziness, vertigo; paresthesias; headache; xanthopsia.

Hematologic: Leukopenia, agranulocytosis; thrombocytopenia, aplastic anemia.

Cardiovascular: Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity: Purpura, photosensitivity; rash, urticaria; necrotizing angiitis (vasculitis, cutaneous vasculitis), fever; respiratory distress, including pneumonitis; anaphylactic reactions.

Other: Hyperglycemia, glycosuria, hyperuricemia, muscle spasm; weakness; restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
April 1986, Volume XXVII, Number 4

ORIGINAL PAPERS

Dirofilaria Immitis As a Cause of Solitary Pulmonary Nodule

ROBERT D. HOLBERT, M.D., WILLIAM THOMAS ROBINSON, M.D.,
and LYMAN J. SCRIPTER, M.D.
Ocean Springs, Mississippi

The incidence of dirofilaria immitis as a cause of solitary pulmonary nodule appears to be expanding in the United States, according to the authors. They discuss diagnosis and treatment, and present a case report.

DASHIEL IN 1961[1] first reported pulmonary infarct in man as a result of embolization of the *dirofilarias immitis* adult worm. This problem has been noted to have increased considerably since the first recognition in 1961 and the number of cases presented in the literature has increased yearly until this time. Apparently, the diagnosis of a embolized end arterial dirofilaria has been made based on lung biopsy related to coin lesions. There have been several attempts to better delineate the type of coin lesion produced by this particular parasite, but as of this reporting, the number of cases diagnosed in ways other than a wedge resection and biopsy have been minimal. We found only[2] one case which was supposed to be a heart worm embolus in man which was not primarily diagnosed by wedge resection. In this report, we describe a patient in whom a coin lesion was diagnosed during routine follow-up evaluation for endometrial carcinoma.

Dirofilaria Immitis has become a more recognized cause of solitary pulmonary nodule. After 1961, the incidence of recorded cases has increased in the literature. It appears that in the endemic areas, the physician must keep this pathogen in his mind as a cause of pulmonary nodules.[3]

As we reviewed this literature and evaluated this particular case, several things became apparent. First, the diagnosis of DI as a cause of solitary (and in one case more than one) pulmonary nodule was almost always diagnosed at the time of surgery and generally was not recognized as a cause of this problem prior to surgery. The roentgenogram, CT scan, and tomography did not appear to give a diagnosis or have criterion delineated to diagnose DI, thereby preventing exploratory thoracotomy. Complement fixation tests[4] and other microfilaria screening techniques do not apparently represent adequate diagnostic techniques to be clinically useful. The incidence of this particular problem appears to be expanding in the United States both in topography and in incidence.[2]

Dr. Holbert is engaged in the practice of internal medicine; Dr. Robinson is a general, thoracic and cardiovascular surgeon; and Dr. Scripter is a pathologist.

In 1887 de Magalhaes[5] reported dirofilariasis in a child while Faustetal discovered dirofilariasis in a cadaver in 1940. After 1961, the filaria has been seen much more often as a cause of pulmonary infarction. In man, the nematode exists only in the form of an accidental infestation. The usual life cycle of DI begins with the male-female present in the right ventricle of the dog. The female produces several thousand microfilariae each day which become present in great numbers in each cubic centimeter of blood in this host. Ticks, fleas, and lice, as well as the more commonly known mosquito, act as vector. The mosquito ingests the microfilariae during a blood meal and further development of the DI occurs in the Malpighian tubules. The third stage of the microfilariae is reached after 10 to 17 days, developing in the salivary tissue. The final development stages of the dirofilariae occur in the salivary tissue and the microfilariae are then presented to the new host by desalivation in the labia of the vector. The host is infected by the direct deposit of the stage III microfilariae onto the surface of the tissue of the accidental host or of the dog. They then enter the host via the skin lesion produced by the vector. In the subcutaneous tissue the filariae continue to develop and finally after 80 to 120 days, they migrate into the venous capillary to the right ventricle. After six days of growth and development, the life cycle repeats itself. In man the life cycle usually does not restart and microfilariae can be embolized to the lung thereby producing arterial infarction and an isolated nodularity based on tissue reaction to the embolized microfilariae.

The distribution of DI has been described as along the Eastern Seaboard and Gulf Coast in the United States.[2] The usual area has been described as about 50 miles inland from the Coast. More recently, the American Kennel Club Heart Worm Society has described the nematode along the Mississippi River valley into the central United States — the higher incidence still occurring in the earlier described location. The recognized incidence of DI appears to correlate with the increased incidence of population, increased incidence of host and vector and with the recognition of this as a cause of solitary nodularity in human lung. As we reviewed the literature in an effort to determine what might have been done in an effort to prevent an exploratory thoracotomy, it was noted that all but one of the previously reported cases was diagnosed utilizing exploratory thoracotomy. The one case that was not diagnosed using exploratory thoracotomy was presumed to be DI based on clinical circumstantial situations. The complement fixation study did not appear to lend valuable diagnostic criterion to this circumstance. Utilizing the CT scanner as well as tomography we were unable to evaluate this particular lesion as being anything other than a solitary nodule, etiology undetermined. The treatment of this particular phenomenon is related entirely to its diagnosis, as wedge resection would certainly be a curative procedure in the case of a solitary nodularity associated with carcinoma. As there were no available reliable techniques to make this diagnosis without resection, it was my opinion that the diagnosis would be made based on an exploratory thoracotomy with resection of the nodule and pathological examination.

Case Report

Mrs. W. S. is a 65-year-old female first seen in the Gautier Medical Clinic in February 1982, for follow-up pap smear because of a history of endometrial carcinoma. The patient had previously received a total abdominal hysterectomy with salpingo-oophorectomy for a well differentiated adenocarcinoma of the endometrium. The surgical procedure was performed in 1980 at the SEKB Hospital, Corbin, Kentucky. During her first evaluation, her pap smear was a Class 1, so she was referred for routine evaluation on a six-months' basis. The patient was treated in this office several times during the next 24 months for routine problems. On March 16, 1984, she came into the office because she had chills, fever and a cough. The physical examination at that time revealed that she had some problem which was related to her sinuses and a diagnosis of sinusitis was entertained. She was noted to have some rhonchi present on auscultation of her chest. A chest x-ray revealed a single parenchymal nodule in the mid-lung field. The follow-up electrocardiogram showed non-specific S-T segment changes. She had a SMA 220 which revealed she had an elevation of her SGPT. A GAMMA-Glyamyl-Transpeptidase was elevated, her LDH was elevated and her SGOT was elevated. Repeat of these parameters revealed elevation of the liver function studies again; triglyceride level was elevated at 327 mgm/%. The patient had tomography performed of the coin lesion described on her chest x-ray and it was read as a suspicious lesion in the left lung field. A computer tomographic scan was read as a single parenchymal nodule, neoplasm cannot be ruled out. CT scan of the liver was read as fatty infiltration of the liver. A percutaneous needle biopsy was at-

tempted on April 23, 1984 with the pathologist's report being of normal lung tissue. The patient developed a pneumothorax after this attempt, and a second attempt at needle biopsy using a CT scanner was discontinued due to the pneumothorax. On April 25, 1984, open thoracotomy was performed with surgical excision of the mass. Frozen section was read as caseation necrosis and debris in a granuloma. The permanent sections revealed arteriole embolization of *dirofilaria immitis*. The patient had an uneventful recovery from her surgical procedures.

Summary

Dirofilaria Immitis has been recognized as an incidental cause of focal pulmonary infarction and described in the literature since 1961. The roentgenographic coin lesion noted from this embolized adult worm has been diagnosed primarily utilizing thoracotomy because of a consideration of malignancy. Many thoracotomies are performed as a diagnostic procedure to evaluate what may be an innocuous process. ★★★

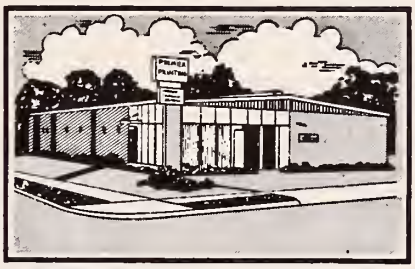
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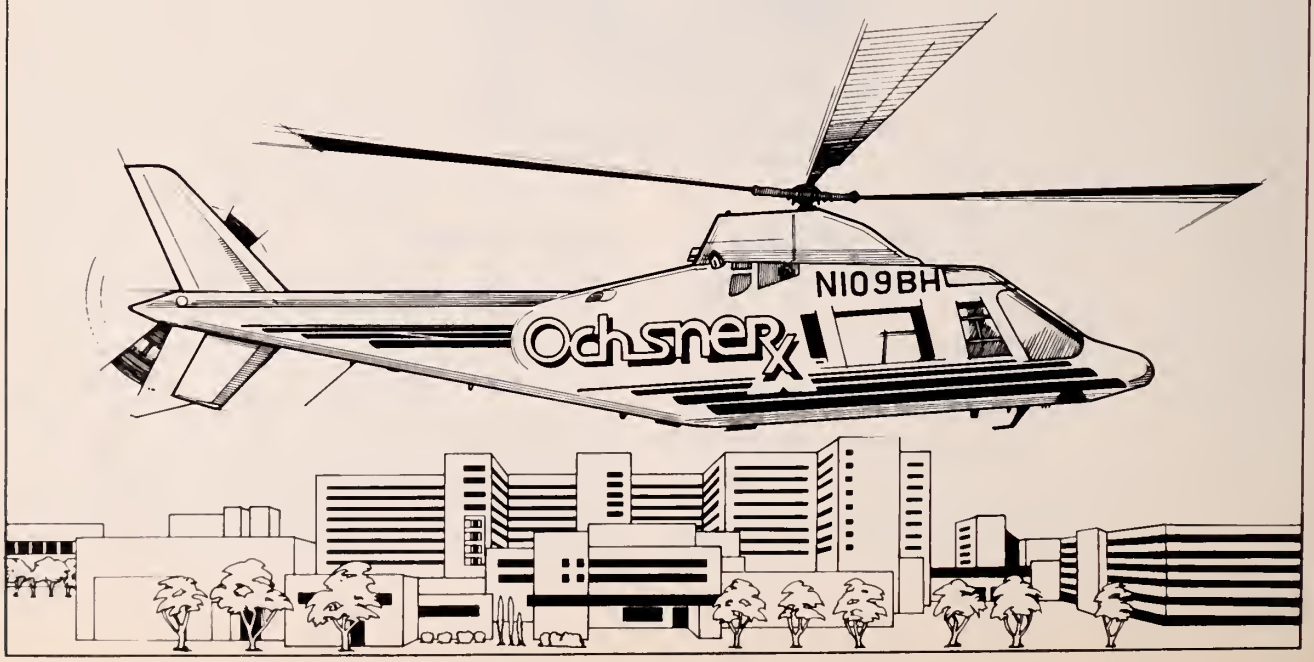
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Radiological Seminar CCXLIV: Digital Subtraction Angiography in The Diagnosis of Subclavian Steal

JAMES U. MORANO, M.D., JAMES L. BURKHALTER, M.D., and CHARLES J. BRDLIK, M.D.
Jackson, Mississippi

SUBCLAVIAN STEAL SYNDROME is caused by a stenotic or occlusive lesion involving the proximal subclavian or innominate artery. Blood flow to the distal subclavian artery and arm then occurs via retrograde flow in the ipsilateral vertebral artery. This altered pattern of blood flow may produce symptoms of cerebral ischemia or ischemia of the ipsilateral upper extremity.

One of the newer radiographic modalities which may have a role in the diagnosis of subclavian steal is digital subtraction angiography. A review of the literature failed to uncover any study in which the diagnostic role of digital subtraction angiography in subclavian steal was specifically addressed. Herein, we report our experience in patients with radiographically proven subclavian steal using digital subtraction angiography techniques.

Material and Methods

Four recent cases of subclavian steal which presented at our institution were reviewed. All of these patients had had a digital subtraction angiogram. In two patients an intravenous injection of contrast was used to obtain the study. In the other two patients the digital subtraction angiogram was acquired from an arterial contrast injection.

All of the studies were obtained on a Siemens Digitron I digital subtraction unit. Both of the intravenous digital subtraction studies were performed by placement of a 5 French Katzen Digiflex catheter (Medi-Tech) within the superior vena cava from the right antecubital approach. Because this catheter has only side holes and a closed distal end, it must be inserted through a sheath. A contrast injection of 35ml of Renografin 76 was performed into the superior vena cava at a rate of 20ml per second.

The arterial digital subtraction studies which are presented were obtained as supplements to conventional arteriograms. The first study (Case 3) was obtained through the same catheter that was being used for conventional selective carotid arteriography. For both the aortic arch and the vertebral artery injections with digital subtraction we diluted the contrast; using three parts Renografin 76 and seven parts normal saline. We injected 30ml of this solution in the aortic arch at 10ml per second. Within the vertebral artery, we injected 7ml of the solution at 3ml per second.

The second arterial digital subtraction study (Case 4) was obtained as a supplement to conventional subclavian arteriography and was performed slightly differently. When the left subclavian artery could not be catheterized, the selective angiographic catheter was advanced into the ascending aorta for performance of an arterial digital subtraction study. In this instance the contrast media was not diluted as in the prior case, but 20ml of full strength Renografin 76 was injected at a rate of 10ml per second.

Results

The four cases which are presented show the capability of digital subtraction angiography in demonstrating subclavian steal. Both of the studies performed by venous injections produced acceptable images for the diagnosis of subclavian steal. The two studies which were done by aortic arch injections yielded images which also permitted the diagnosis, but were performed with less contrast volume than would have been necessary with conventional aortic arch arteriography.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, University Medical Center, Jackson, MS.

Case 1. This 52-year-old white male was admitted for evaluation of severe hypertension. He was noted on physical examination to have a diminished radial pulse on the left. He had a blood pressure of 180/120 in the right arm and 120/100 in the left arm. The patient did not have any symptoms of cerebral or upper extremity ischemia, however. As part of his work-up for hypertension, he received an intravenous digital subtraction angiogram to rule out renal artery stenosis. After the renal arteries were evaluated, two additional contrast injections were made with centering over the left subclavian area. Both PA and LAO (see Figure 1) projections were obtained; these demonstrated occlusion of the proximal left subclavian artery with filling of the distal subclavian artery by retrograde flow in the left vertebral artery.

Case 2. This 59-year-old white female was admitted for evaluation of her diffuse peripheral vascular disease. She did not have any symptoms of cerebral or upper extremity ischemia, however. She was noted on physical examination to have diminished brachial and radial pulses on the left. A blood pressure of 174/94 was obtained in the right arm, and 130/90 in the left. Intravenous digital subtraction angiography done in the LAO projection (see Figure 2A and Figure 2B) revealed occlusion of the proximal left subclavian artery with later filling of the distal subclavian artery by retrograde flow in the ipsilateral vertebral artery.

Case 3. This 61-year-old white male was admitted for evaluation of a three year history of "blackout spells" manifested by syncope and loss of vision. On preliminary evaluation with Doppler examination, the presence of a left subclavian steal was diagnosed and diminished Doppler pressures were documented in the left arm. The patient also



Figure 2A. Intravenous DSA; LAO projection, Case 2. Early phase images demonstrate occlusion of proximal left subclavian artery.



Figure 1. Intravenous DSA; LAO projection, Case 1. Occlusion of proximal left subclavian artery with filling of distal subclavian artery by retrograde flow in left vertebral artery.



Figure 2B. Intravenous DSA; LAO projection, Case 2. Later phase images show filling of distal left subclavian artery by retrograde flow in vertebral artery.

had a diminished radial pulse on the left. As part of his work-up, the patient underwent cerebral arteriography. Immediately following selective bilateral carotid examinations by conventional arteriography, injections were made through the same catheter placed in the ascending aorta, and later the right vertebral artery, in the fashion described earlier for arterial DSA (see Figure 3A and Figure 3B). This revealed occlusion of the proximal left subclavian artery with filling of the distal subclavian artery by retrograde flow in the left vertebral artery.



Figure 3A. Arterial DSA: LAO projection, Case 3. Aortic arch injection shows occlusion of left subclavian artery at its origin.



Figure 3B. Arterial DSA; AP projection; Case 3. Catheter can be seen selectively injecting contrast into right vertebral artery. The majority of the contrast is now seen flowing retrograde in the left vertebral artery, reconstituting the left subclavian artery.

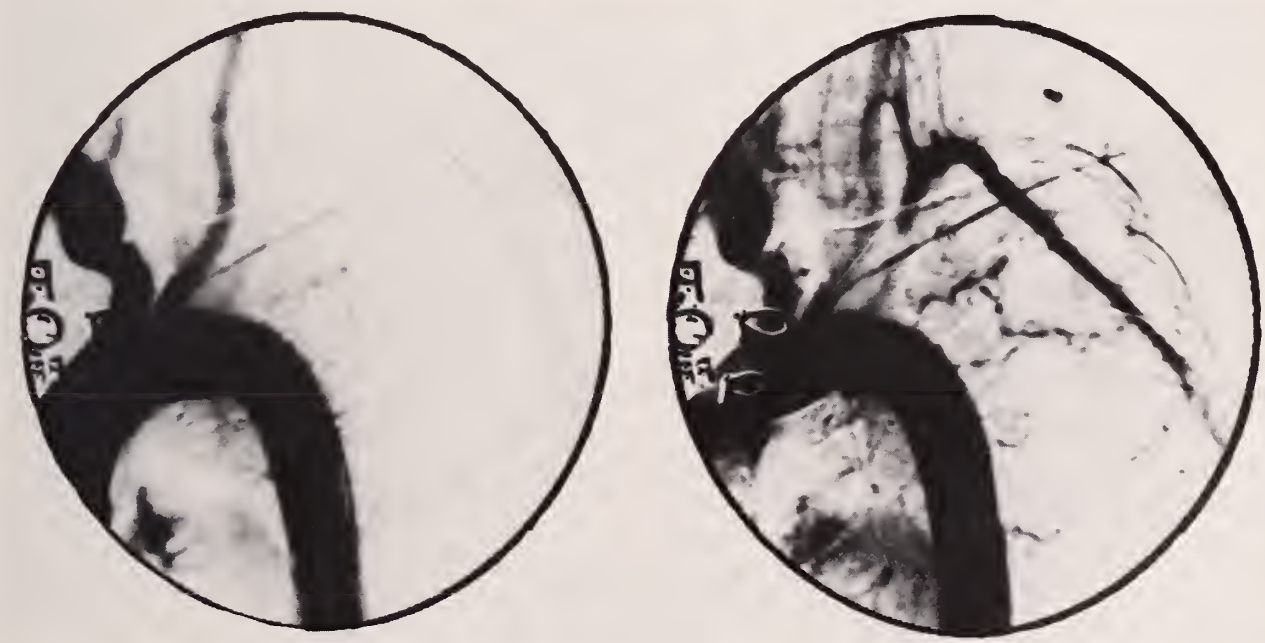


Figure 4. Arterial DSA; LAO projection, Case 4. Aortic arch injection demonstrates occlusion of left subclavian artery on earlier image, and filling of distal subclavian artery by retrograde flow in left vertebral artery on later image.

Case 4. This 33-year-old black female complained of some subtle soft tissue swelling in the left supraclavicular area of several months duration. Since she also gave a history of a stab wound to this area several years earlier, a subclavian arteriogram was requested to rule out a post-traumatic vascular lesion. At arteriography the origin of the left subclavian artery could not be found. The angiographic catheter was then advanced into the ascending aorta, and arterial DSA was performed in the manner discussed earlier (see Figure 4). This revealed occlusion of the left subclavian artery at its origin with filling of the subclavian artery by retrograde flow in the ipsilateral vertebral artery.

It is particularly interesting to note that this patient had a hemodialysis access fistula in the left arm, and had been receiving hemodialysis within the arm affected by the subclavian steal for two years. Upon discussion with the patient after the procedure, she admitted to occasional episodes of dizziness and numbness in the left arm.

Discussion

Subclavian steal is responsible for approximately 4% of all cases of cerebrovascular disease.[7] It is more common in men than women.[9] A significant majority of cases occur on the left side.[4]

Subclavian steal is caused by a stenotic or occlusive lesion involving the proximal subclavian or innominate artery. These lesions may be either acquired or congenital. The most common lesion to cause subclavian steal is atherosclerotic.[6] There are many other possible etiologies for acquired lesions that may cause subclavian steal, including arteritis, trauma, embolus, or thrombus formation, and tumor encasement.[9] Subclavian steal may also result subsequent to a previous surgical procedure. Examples of this would include post-surgical stenosis of the proximal portion of the left subclavian artery after repair of a coarctation and surgical ligation of the subclavian artery during a Blalock-Taussig procedure.[8]

Although much more rare, congenital lesions may also be responsible for the presence of a subclavian steal. These congenital cases are frequently related to an aortic arch anomaly, such as a right-sided aortic arch. The etiology for the development of a subclavian steal in these cases is often atresia, hypoplasia, or partial occlusion of an anomalous left subclavian artery.[8]

An occlusive or stenotic lesion of the proximal subclavian artery may not always be necessary for a subclavian steal to occur. It has been postulated, based on several case reports and blood flow measurements, that post-ischemic reactive hyperemia of the arm, such as occurs following deflation of a pneumatic tourniquet for extremity surgery, may produce an acute subclavian steal syndrome even in the absence of a significant subclavian stenosis.[3]

Subclavian steal may produce symptoms of cerebral ischemia and/or ischemia of the ipsilateral upper extremity. However, it may be asymptomatic even in the presence of radiographically proven subclavian steal.[2] Children are more likely to be asymptomatic than adults.[8]

Among symptomatic patients the neurological symptoms tend to occur more commonly than the arm symptoms.[7] The neurological symptoms are secondary to ischemia in the vertebrobasilar circulation and may include vertigo, syncope, ataxia, confusion, and others. However, the ischemic symptoms from subclavian steal are not always restricted to the posterior fossa circulation. Ischemic effects may also occasionally be seen within the carotid artery territories secondary to extension of the "steal" phenomenon to involve the circle of Willis.[9] Ischemic symptoms within the arm include claudication, easy fatigability, and paresthesias.

Several signs on physical examination are supportive of the diagnosis of subclavian steal. Often there is an absent, diminished, or asynchronous radial pulse on the involved side. A differential in blood pressure of at least 20mm Hg is frequently recorded between both arms. A supraclavicular bruit may be heard. A helpful sign when it occurs is the appearance of neurologic symptoms when the involved arm is exercised; however, this test is frequently falsely negative.[8]

Several tests are available for confirmation of a suspected diagnosis of subclavian steal. Non-invasive Doppler studies can accurately diagnose subclavian steal and differentiate it from subclavian stenosis without steal by having the ability to detect reversed flow in the vertebral artery.[9] Unfortunately, the Doppler examination does not provide the more detailed anatomic information that the surgeon often requires.

Aortic arch angiography has been the primary means of diagnosing subclavian steal and obtaining detailed anatomic information about the lesion. With arteriography the proximal subclavian lesion can be well defined on the arterial phase of the injection. On the more delayed films of the aortic injection, filling of the distal subclavian artery can be seen by retrograde flow in the ipsilateral vertebral artery. Arch aortography is considered superior to a selec-

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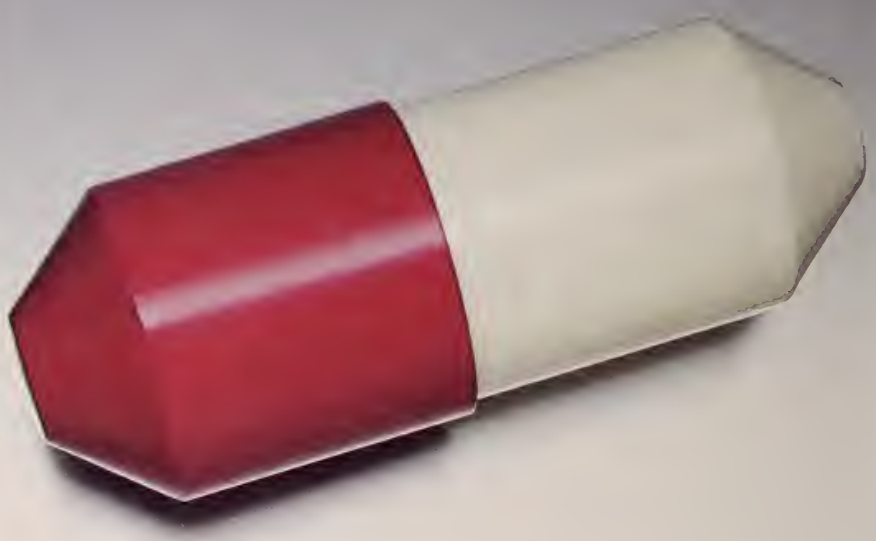
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tive injection of contrast media into the contralateral vertebral artery since a vertebral artery injection alone will not demonstrate the proximal subclavian lesion well. In addition, a selective vertebral artery injection may produce some transient retrograde flow in the opposite vertebral artery even in the absence of a true subclavian steal, thus confusing interpretation.[8]

Digital subtraction angiography provides an additional means of obtaining images and anatomic information about a patient with subclavian steal. There are several advantages of intravenous DSA over conventional arch aortography. Since the arterial system is not entered, the more serious potential complications of an arterial catheterization can be avoided. For the same reason patients with severe hypertension, bleeding disorders, or on anticoagulation therapy can be studied with less concern for post-procedural bleeding problems at the puncture site. An intravenous DSA is also often less expensive than a conventional arteriogram, and can more easily be performed on an out-patient basis. Occasionally, the intravenous examination can be completed using less contrast than would ordinarily be used in routine arch aortography, reducing further the risk of contrast nephrotoxicity.

One additional advantage to using the intravenous DSA in the symptomatic patient relates to planning for possible transluminal angioplasty. Percutaneous angioplasty has occasionally been employed as an alternative to surgical treatment in some cases of subclavian steal.[1, 5] The information gained from a DSA study may influence the selection of a femoral artery versus axillary artery approach for the angioplasty catheter. If the DSA shows the subclavian artery to be occluded flush with the surface of the aorta, the usual femoral approach would be less likely to succeed and an axillary approach might be preferable. If some patent lumen of the subclavian artery remains proximal to the occlusion; however, the usual femoral approach would be likely to succeed.

Unfortunately, there are also some disadvantages to intravenous digital subtraction angiography. Because of the subtraction technique, any patient motion will degrade the quality of a DSA image more than a conventional arteriogram, and thus a higher degree of patient cooperation is required. In addition, a poor cardiac output may cause a decrease in the degree of arterial opacification achieved, and thus decrease the quality of an intravenous DSA. This is not generally a factor in an arteriogram. The field size of any DSA study is smaller than with an arteriogram. Probably the greatest advantage of a conventional arteriogram over intravenous DSA, however, is its superior image quality and detail.

The arterial digital subtraction angiogram produces better image quality and detail than an intravenous study, but the image detail is not superior to a conventional arteriogram. The arterial digital study is also more sensitive to patient motion than the routine aortogram. However, the arterial digital study has the advantage of requiring a smaller volume of contrast media to obtain images than either an intravenous DSA or a conventional aortogram.

Summary

In conclusion, digital subtraction angiography provides an additional means of diagnosing and obtaining images of subclavian steal. However, the role which digital subtraction angiography should play in the diagnosis of subclavian steal is not always clear and is probably somewhat limited at this time. As a screening study, the Doppler examination is probably superior to the DSA in that it provides a non-invasive means of detecting the presence of subclavian steal without giving contrast media. However, DSA has the advantage of providing images of the anatomy; and intravenous DSA could be considered as an alternate screening procedure, especially at hospitals where Doppler examinations are not available.

As a definitive study for surgical planning, the conventional arteriogram is often preferred over a digital subtraction angiogram because of its superior image quality and detail. In addition, arteriography allows for a more complete and detailed evaluation of the remainder of the cerebrovascular system which is frequently involved by the same diffuse atherosclerotic disease process. However, there are some specific circumstances in which DSA may be desirable over a conventional arteriogram. In the patient with compromised renal function, an arterial DSA can provide a high quality study using significantly less contrast volume and thus be less likely to cause further deterioration in the patient's renal disease. In patients who are at increased risk for arterial catheterization, such as those on anticoagulation therapy or with severe hypertension, the intravenous DSA may prove adequate for treatment planning without subjecting the patient to an arteriogram. With the rapid developments occurring in digital subtraction angiography and as the surgeons grow familiar and confident with this modality, it is possible that digital subtraction angiography may become preferred over conventional arteriography in more and more instances. ★★★

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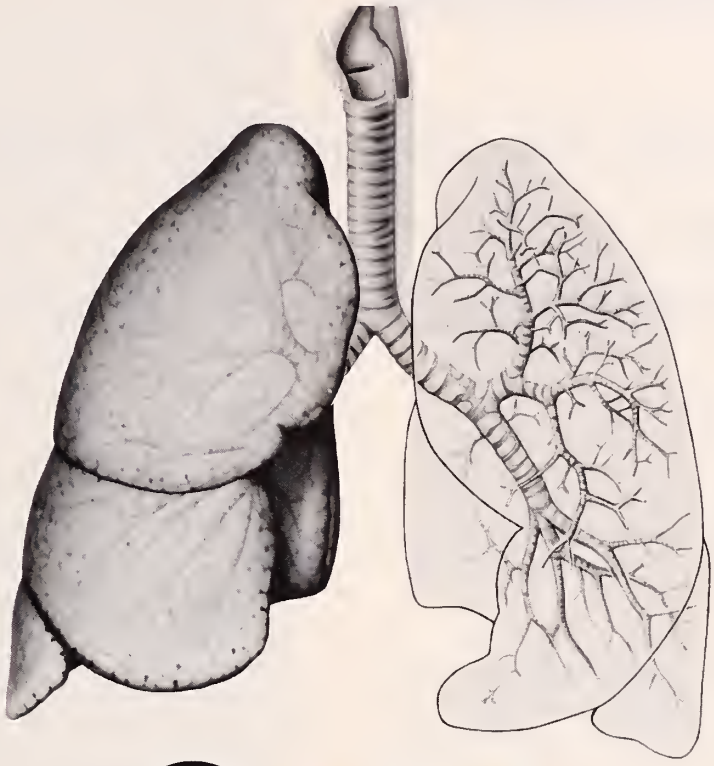
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(ampicillin-susceptible) (ampicillin-resistant)

Brief Summary: Consult the package literature for prescribing information.

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal *Relationship Uncertain* — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note: Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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SPECIAL ARTICLES

Statement on Granting Hospital Privileges to Perform Gastrointestinal Endoscopy*

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Jackson, Mississippi

JAMES E. SPENCE, M.D.
Hattiesburg, Mississippi

THIS STATEMENT was prepared by the American Society for Gastrointestinal Endoscopy's (ASGE) Committee on Standards of Training and Practice. The recommendations are based on the committee members' experience with the granting of hospital privileges to perform gastrointestinal endoscopy.

I. **Principles of Credentialing**

A. Purpose

The purpose of this statement is to outline principles and provide practical suggestions to assist hospital credentialing committees in their task of granting privileges to perform gastrointestinal endoscopy. In conjunction with the standard JCAH guidelines for granting hospital privileges, implementation of these methods should help hospital staffs insure that endoscopy is performed only by individuals with appropriate competency, thus assuring high quality patient care and proper procedure utilization. The goals must be quality assurance, patient protection, and cost containment, not arbitrary restraint of practice.

B. Statement of the Problem

The general principles defining competency in gastrointestinal endoscopy are provided by the ASGE guidelines on the *The Standards of Practice of Gastrointestinal Endoscopy* and the *Statement of Endoscopic Training*. These guidelines have been approved by the Governing Boards of the American Society for Gastrointestinal Endoscopy, the American Gastroenterological Association, the American College of Gastroenterology, and the Society for Surgery of the Alimentary Tract. Although hospitals have frequently used these guidelines in their independent development of credentialing standards, many have requested more specific or practical suggestions on how these principles might be best implemented.

C. Uniformity of Standards

Uniform standards should be developed which apply equally to all hospital staff requesting privileges to perform endoscopy, and to all areas where endoscopy is performed within a given institution. Criteria must be established which are medically sound, not unreasonably stringent, and which are applicable in common to all those wishing to obtain privileges in each specific endoscopic procedure.

D. Specific Credentialing

Privileges should be granted for each major category of endoscopy separately. The ability to perform one endoscopic procedure does not imply adequate competency to perform

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Drs. Long and Spence are respectively president and secretary-treasurer of the Mississippi Gastroenterology Society.

This Mississippi Gastroenterology Society is composed of gastroenterologists and surgeons from throughout Mississippi. In recent months the Society has received an increasing number of requests by physicians from across the state for guidance concerning the granting of hospital privileges for gastrointestinal endoscopy. It seems that more and more community hospitals are purchasing endoscopic equipment and creating a need for local physicians to utilize this technology.

According to the authors, what bothers these inquiring physicians most is the feeling that those requesting endoscopic privileges are not, in some instances, properly trained. The concept of "grandfathering" for those physicians who began performing gastrointestinal endoscopy prior to the beginning of current standards remains a local hospital issue. The credentialing committee must assure that the same level of quality standards are being met by all endoscopists. It seems clear that short courses and unsupervised endoscopy learning experiences (i.e., outside a formal surgical residency or gastroenterology fellowship) no longer qualify as acceptable training. Periodic reevaluation of endoscopic privileges is important for the maintenance of optimal patient care.

In an effort to provide those members of the hospital medical staffs involved in credentialing and to provide hospital boards of trustees with the current recommendations, the contributors furnish this copy of these quidelines.

another. Associated skills generally considered to be an integral part of an endoscopic category may be required before privileges for that category are granted. For example, competency in polypectomy and electrocoagulation must be documented before colonoscopy privileges can be granted. The application for privileges will require adequate verification of competency for each procedure separately.

E. Responsibility for Credentialing
Determination of who does credentialing and which specific methods are chosen to examine the process remains always the individual responsibility of each hospital. When defining privilege granting criteria and procedures, it should be kept in mind that *hospital trustees and all medical staff share common responsibility and liability* for all procedures performed within their institution. It is highly desirable to establish a *multidisciplinary endoscopic procedure committee* to advise the credentialing body regarding initial granting of privileges, to monitor ongoing procedure performance and outcome, and to assist in the renewal of privileges. Every attempt should be made to cooperate between hospitals with overlapping staff to reduce the time and paperwork in the credential granting process.

F. Competency in the Diagnosis and Management of Gastrointestinal Disorders
The decision of who should perform gastrointestinal endoscopy in a given hospital should be based on the applicant's knowledge, training, and experience in the overall management of gastrointestinal disease, as well as competency to perform the endoscopic procedure. *The perceived need by a hospital to provide endoscopic services, or the need for additional hospital revenues, are not acceptable reasons to allow untrained physicians to attempt gastrointestinal endoscopy*. The quality of patient care will be compromised, and grave liability consequences could arise for hospital trustees and the medical staff.

Flexible sigmoidoscopy is generally considered a separate category. With adequate supervised training it may be performed by physicians without other endoscopic skills or specialized training in gastroenterology or surgery (see ASGE guidelines on *Flexible Sigmoidoscopy*). Flexible sigmoidoscopy *is not equivalent* to left-sided colonoscopy.

II. **Definition and Documentation of Competency**

A. Formal fellowship or residency training in gastroenterology or surgery:

1. Duration of Training
Training should be of adequate duration to provide familiarity with the patients and diseases requiring endoscopic evaluation. There must be an understanding of the indications,

complications, and expected advantages of diagnostic and therapeutic endoscopy, as well as cost considerations, and comparisons with alternative approaches.

2. Endoscopic Experience
The total time spent during training, learning and performing endoscopic procedures must be adequate for each major category for which privileges are requested. The number of cases which must be observed, performed under supervision and performed independently necessary to obtain competency varies tremendously. The following number of cases performed personally by each trainee during training should serve as a guideline for *minimal* required endoscopic experience:

Esophagogastroduodenoscopy	— 50
Colonoscopy	— 50
Polypectomy	— 15
ERCP	— 50

3. Certification
The applicant's endoscopic training director should confirm in writing the training, experience (including the number of cases for each procedure for which privileges are requested), and actually observed level of competency.

B. Training and experience outside of a formal fellowship or residency program:
Equivalent training, obtained outside of a formal program, must be equal to that described above. Certification of experience by a skilled endoscopic practitioner must include a detailed description of the nature of ''informal'' training, the number of procedures performed with and without supervision, and the actual observed competency of the applicant for each endoscopic procedure for which privileges are requested. It is generally *no longer acceptable* for physicians to acquire equivalent endoscopic experience by performing unsupervised procedures when skilled endoscopists are available in the medical community. Likewise, attendance at short endoscopy courses which do not provide supervised, hands-on training experience with patients *is not an acceptable substitute* in the development of equivalent competency (see ASGC guideline — *The Statement on Role of Short Courses in Endoscopic Training*).

C. New Procedures
As endoscopy evolves, new procedures develop for which privileges may be requested. The process for credentialing depends on the background skills and privileges of the applicant and whether the new procedure is a minor or major variant of established techniques. For minor extensions of demonstrated skills, reading or viewing video tapes may be sufficient training. Some new procedures may require formal training or ''hands on'' equivalent supervised experience with adequate written documentation. Endoscopic sphincterotomy is an example of an extremely complex and high risk procedure requiring extensive training and experience. Therefore, privilege granting for endoscopic sphincterotomy requires documented competency.

D. Proctoring
Recognizing the limitations of written reports, proctoring of applicants for privileges in gastrointestinal endoscopy by a qualified, unbiased staff endoscopist may be desirable, especially when competency for a given procedure cannot be adequately verified by submitted written material. Proctors are chosen from existing endoscopy staff or are solicited from regional endoscopic societies. Criteria of competency for each procedure should be established in advance. It is essential that proctoring be carried out in an unbiased, confidential, objective manner. The procedural details of proctoring should be provided to the applicant in written form. Recommendations and opinions resulting from proctoring should be submitted in writing both to the applicant and to the credentialing body of the hospital. A satisfactory mechanism for appeal must be established for individuals for whom privileges are denied or are granted in a temporary or provisional manner.

E. Monitoring of Endoscopic Performance
To assist the hospital credentialing body in the ongoing renewal of privileges, a mechanism should be developed to monitor each staff endoscopist's procedural performance. A *multidisciplinary endoscopy committee,* as described above, could be charged with

monitoring endoscopic utilization, diagnostic and therapeutic benefits to patients, complications, and tissue review. A minimum number of cases performed each year for each major endoscopic category may be required to renew privileges. These functions should be accomplished using established peer review methodology and available endoscopic audit criteria. The committee should review in an unbiased random sample the appropriateness of the indications for endoscopy, the impact on management of the patients' problems, the nature and adequacy of safety precautions, and the incidence and cause of all complications. Guidelines for the utilization of endoscopy prepared by the American Society of Gastrointestinal Endoscopy and other societies are available to assist in the periodic reassessment of endoscopic privileges.

F. Continuing Education

Continuing medical education related to endoscopy should be required as part of the periodic renewal of endoscopic privileges. Attendance at appropriate local or national meetings and courses is encouraged.

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The President Speaking

Grand-Slam Homer

Ralph L. Brock, M.D.
McComb, Mississippi

Throughout this year I have compared medical practice in Mississippi to a baseball game. Last summer it was as if it were in the bottom of the seventh inning and we were behind 3 to 1. The "3" against us were: Hospitals, Insurance Companies, and Big Business. I would like to bring you up-to-date on results in the later innings.

We went into the top of the eighth in the fall. When our association accepted unification with the AMA with an overwhelming response, it was as if we retired their side "3 up and 3 down." We took our turn at bat in the bottom of the eighth last December. We loaded the bases when the prospectus for the statewide HMO/IPA was mailed on December 16.

On February 28 the HMO/IPA was oversubscribed and a grand-slam homer went over the fence. We then took the lead for the first time: 5 to 3.

But the game is not over! We have excellent physicians practicing in the state who are not members of the MSMA, and we need them to be a part of our team.

At the 1985 Regular Session of the House of Delegates, a resolution was passed that expanded the membership development committee. This committee has met and outlined plans to contact all non-members and invite them to join our team that is coming together with unified strength and purpose as never before. Contacts will be made by phone, letter, in person, or a combination of any of the three. Whether or not you are asked to make some of these contacts, I hope you will learn as much about what is going on at the local, state and national level of organized medicine, then talk to the non-members and encourage them to join. You can get a list of the prospects from the MSMA headquarters.

You will be hearing more about the development of the HMO/IPA in the weeks and months to come. Many crucial decisions will have to be made and physician input from all parts of the state and every specialty group will be needed to make many of these decisions.

The annual session coming up in June will probably be one of the most interesting and best attended on record. Simply put, we have more going on involving our members than ever before.

(Continued on page 101)

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XXVII, Number 4

APRIL 1986

Thank You, Dr. Long

The MSMA Committee on Publications meets regularly to review the business management aspects of publishing your Journal. Points of interest are: publication costs (paper, printing, artwork, etc.), printing contracts, relationship with advertisers and agencies, and publication policies. This committee is responsible to the MSMA Board of Trustees.

For many years Dr. Lawrence C. Long has chaired this important committee. Dr. Long was directly responsible for getting the association to acquire this publication from a private publisher and establish it as the *Journal of the Mississippi State Medical Association*. Because of his dedication and hard work as chairman of the Committee on Publications, members of this society have enjoyed the benefits of a quality state medical journal. In appreciation for these efforts, the editorial staff and committee members express their thanks.

MYRON W. LOCKEY, M.D.
Editor

THE PRESIDENT SPEAKING

(Continued from page 100)

Mississippi Foundation for Medical Care is entering the private review field, and it is hoped that this will be received with wide acceptance. Many will want to sit in on their annual meeting to get a progress report on these activities as well as find out the latest on: "What have they done to us now?" on the federal level of review.

Medical Assurance Company is getting more applications for liability insurance coverage now that St. Paul Insurance Company is cutting back on their participation in the state. The annual meeting of MACM will probably we well attended.

The House of Delegates meeting of the MSMA should be "standing room only" with interest on all matters running high. The headquarters building program is well underway and the HMO/IPA progress report will be of interest to all.

Make your plans now for the annual session and get your hotel reservations in early. If you can't come, be sure there is representation from your practice group and medical staff.

I encourage you to take an active part in our membership drive. We need our team to be as strong and effective as possible. We need to protect our lead and let the opposition know that we mean business, the same as when the grand-slam homer went over the fence.

Auxiliary Project Provides Medi-Cards for Patients

Through a project coordinated by the MSMA Auxiliary and supported by the MSMA, patients who take a number of prescription drugs may obtain medical record cards to keep in their wallets. Physicians who wish to distribute the cards to their patients may place an order by calling the Auxiliary office at MSMA headquarters. There is no charge for a supply of Medi-Cards.

The bright yellow cards have places for recording all medications, dosages, prescribing doctor's name, and date of prescription. There is also a place to indicate any allergies. The cards include places for recording important phone numbers and Medicare identification number, along with tips on using medications wisely.

"We feel that this project will be a great benefit to patients, particularly older ones who take a number of prescription medications," said Mrs. Linda (Ben) Martin, president of the MSMA Auxiliary. She pointed out that the project also will demonstrate the concern the profession has for patient safety and convenience.

COMMENT

The Breaking of a Surgeon

When I was a child my mother often suggested I consider becoming a doctor. I did consider it. I went into engineering. It was dry and uninteresting. It was also interrupted by an overt fear of becoming an active participant in a "police action" taking place in Korea. I knew I couldn't finish school without financial help. The G.I. Bill looked adequate. The recruiter assured me if I volunteered I could choose where I wanted to go.

I volunteered.

They accepted.

I chose Europe.

I went to Korea.

I caught fulminating tinea pedis. The medic called it "jungle rot," although I never saw a jungle. He gave me a bottle of APC's, an olive colored can of Desenex, and a Purple Heart. He sent me back to my unit. I didn't even get service-connected disability when discharged. My feet still itch.

I finally became a doctor. I almost didn't make it — not because of grades, but because I wasn't sure. My father-in-law, affirming it to be true, told me about the "olden days" when a neighbor often called his doctor for house calls. The doctor always complied, and after each visit the man would ask the doctor for a ride into town. The doctor, realizing the man was never really sick, asked him what he was up to. The man admitted that the doctor charged less for a house call than the taxi service charged for a ride into town. For a long time I thought about being a taxi driver.

I became a surgical specialist. I went into private practice.

I became concerned over the number of patients I saw who expounded their previous excellent health and ability to perform gargantuan feats until:

a. Being in an accident caused by someone else.
b. Getting hurt on the job.
c. Getting hurt on someone else's property.
d. All of the above.

Following said accident, they continued to experience constant, tortuous agony, and be unable to perform even the most trivial activity, except possibly hunting or fishing. For a long time I suspected there were many aftereffects of trauma they forgot to teach me about in training.

These patients' lawyers were usually very sympathetic and empathetic. They were extremely concerned over their clients' serious physical condition and extreme degree of disability, especially the unlikely event they would ever recover.

The lawyers for the other side usually seemed to be somewhat paranoid. They appeared to be convinced that the world was unjustly after their clients' money.

I called them like I saw them. This did not always make everyone happy. It was sometimes suggested or implied that I was mistaken, misguided, eroneous, coerced, bribed, bought, unqualified, or just plain wrong. Sometimes this was done by the plaintiff's lawyer, and sometimes by the defendant's lawyer. After a particularly brutal session, the attacking attorney came over to apologize. He said it was his job. I offered to help him find a better one. The next occasion his attack was so vigorous I'm sure I saw St. Elmo's fire surround the witness stand. He gave an award-winning performance for sincerity. He also forgot to apologize.

I became somewhat paranoid myself. My office staff screened new appointments very carefully. If they had a lawyer, or if there was any form of pending litigation, we could probably work them in — in about eight or nine months. Some even kept their appointments. None got well — at least while I was treating them. I guess they must have eventually given up. After their settlements, I never saw them again.

Medicaid was introduced shortly after I went into practice. I never was very business-minded, so I never understood how they always seemed to know how much it cost to render a professional service, since they always paid exactly half of the actual cost. Originally, they paid about what it cost to complete the form. I could understand that the system needed subsidization, but I couldn't understand the logic of other sick people having to subsidize it. Since I wasn't very business-minded, I guess I wasn't expected to understand.

Medicare was somewhat better. They would pay me $18.56 to get up in the middle of the night, drive to the hospital, make untold efforts at stamping out disease, return home just in time to shower and shave, then return to the hospital for morning rounds or surgery. That was at a time when my air conditioning man, when called on a hot July Friday, advised me he could probably come the following Monday to determine why my system suddenly became comatose. He did. He charged me $45.00 for a diagnosis. My unit must have needed very inten-

sive care. I needed catastrophic coverage for treatment.

Medicare paid other doctors in other towns and other states more. A few got less. They told me that according to their calculations I didn't need as much. My banker didn't agree. I became suspicious of discrimination.

Medicare was also very helpful with patient rapport, often implying that their doctor was a bandit, or at least charged "unreasonable" fees. Medicare would pay 40-60% of the actual charge, and use very descriptive but psychologically loaded terms for their payment, such as: "usual and customary," a term not seemingly related to any physician's admitted usual or customary charges; "reasonable charge"; "customary charge"; "prevailing charge"; and more recently a slightly more accurate term — "allowable charge." The latter usually had an occult and obscure connection with an even more nebulous abstraction, referred to as the "economic index." This, in turn, was used as a multiplier of the 1973 "profile," which remained essentially unchanged for a number of years due to an extended price-wage freeze. This 1973 profile remains mysteriously unavailable when requested. Since it is so unavailable, it is even more mysterious how it can be used for these calculations. Very ingenious.

More recently another excuse was introduced to reduce payment. I was advised on several occasions that a "lesser service would have sufficed." I suppose this means that the quality of care is to be reduced. I was impressed with their ability to render remote clinical judgments without the benefit of all the facts.

I really became unhappy when I treated a rather elderly friend, a pillar of the community, for a series of improbable events that culminated in a 90-day hospitalization that, almost incidentally, involved surgery. I accepted assignment and received payment for about 60% of the surgical fee, but no payment for other services although they were unrelated to the surgery. Since this approximated minimum wage, I appealed. It was denied. I requested a "fair hearing." A "hearing" was held several months later, without prior notification, by an "impartial" officer whose salary was paid by the Medicare carrier. The claim was again denied. I was not advised of any other recourse, but I did find out I was prohibited from taking the matter to any court. The reverse was not true. I become more suspicious of discrimination.

More recently I was told that my Medicare patients could have one of 470 different entities. I'm not sure what would happen if they developed something more exotic. My patients love to do that.

"I finally became a doctor. I almost didn't make it — not because of grades, but because I wasn't sure. My father-in-law, affirming it to be true, told me about the 'olden days' when a neighbor often called his doctor for house calls. The doctor always complied, and after each visit the man would ask the doctor for a ride into town. The doctor, realizing the man was never really sick, asked him what he was up to. The man admitted that the doctor charged less for a house call than the taxi service charged for a ride into town. For a long time I thought about being a taxi driver."

This mandate was followed by a 15-month fee freeze, which functionally results in a 36-month fee freeze, which incidentally was enacted by a law that functionally extended itself retroactively 18 days. It didn't seem to make any difference that this is specifically prohibited by our Constitution. I became overtly suspicious of discrimination.

In the past, paperwork wasn't bad. I did consider unnecessary the full page form as to why a one-legged man needed crutches. More recently the physician has been required to sign a statement on each hospital patient that he is telling the truth. This blatantly questions the integrity of the physician, and is obviously insulting. I was convinced there was discrimination.

After several years of hassle with Medicare, I saw a lawyer. He was polite and smiled a lot. Two years later I saw another lawyer. He did more than the first. He told me he had no idea what I was talking about. I began to wonder if I had paranoid tendencies.

On one occasion a representative of a newly-formed preferred provider organization came by enlisting physicians. The idea of being preferred was enticing. His hair suggested he had just received an electric shock. He wore a small gold chain around his neck and didn't button the top three buttons of his shirt. He explained that if I gave his clients a sizeable discount, plus pay him a percentage of what his clients did pay, he would send me patients. I asked him how this differed, in the final analysis, from fee-splitting and kick-backs. His nostrils flared and he developed vertical wrinkles between his eyebrows. After considerable stammering and hesitation he explained that the intent was different, but agreed that the intent in both situations was to make money. He then suggested I probably wouldn't be

"More recently I was told that my Medicare patients could have one of 470 different entities. I'm not sure what would happen if they developed something more exotic. My patients love to do that."

happy with his company. He left abruptly, mumbling as he left.

Taxes perpetually disturbed me. I never found any of those "loopholes" I had heard about. They told me if I didn't pay these taxes they would take my belongings and probably put me in prison. They said this wasn't confiscation, but my "fair share." I told them I didn't think my share was very fair. One of the representatives laughed so hard he got strangled. I attempted to perform a Heimlich maneuver on him. He almost had me arrested for assault.

I was told I could not discriminate against anyone on the basis of race, creed, color, national origin, age, sex, disability or anything else. However, there was a constitutional amendment that specifically stated I could be discriminated against on the basis of income.

I began to babble semicoherently about geographic discrimination, economic discrimination, deprivation of due process, ex post facto, political expediency, unfair practices, etc. I couldn't take it any longer. I talked it over with a friend of a friend, who incidentally was a psychiatrist. After I told him my story, he said it sounded very paranoid. However, since he was also a doctor, he knew that every word was true. He also mentioned a concept proposed by a famous psychiatrist — that since society itself is so sick, perhaps the sickest people are those who appear to be so well-adjusted, while those who appear to be maladjusted are perhaps healthy after all. Suddenly, I felt very healthy.

I try not to think about it very much. However, occasionally it becomes overbearing. I fall to the floor, assume the fetal position, suck my thumb, and hum. I have visions of the dodo bird, who in its false security when not exposed to predators, lost its ability to fly, and became totally extinct when exposed to man, who found the bird easy prey. I hear the wind softly whisper: "Big Brother is coming," "Big Brother is coming.". . .

DONALD E. COOK, M.D.
Meridian, MS

Medico-Legal Brief

University Discriminated Against Female Physician, Court Finds

A state university discriminated against a female physician by failing to hire her as a staff physician, a federal appellate court for Florida ruled.

The physician was interviewed for a position as staff physician at the university health center in August 1975. The director of the health center submitted her name along with the names of five other applicants to his superior requesting authorization to hire all six physicians. He approved the hiring of the first four physicians on the list. Since the female physician was number five on the list, she was not hired. She was informed by the director that he had not received approval to hire her but that she was next on the list and would have the first opportunity for the next position that opened.

Despite several vacancies for staff physicians at the health center over the next year, the physician was not hired. She filed an action in federal court for damages and an injunction for employment discrimination. A federal trial court found no discrimination, but a federal appellate court remanded the case. On remand, the trial court again found against the physician, and she appealed.

On appeal, the federal appellate court noted that job offers had been made to four male physicians for jobs as staff physicians at the health center. The court also noted that the female physician was actively in the running for a position as staff physician during the period of time when the four male physicians were hired. The physician made out a case of sex discrimination for the university's failure to hire her as a staff physician.

The university failed to rebut her case. The university failed to show by a preponderance of the evidence that all those to whom the position was offered were better qualified than she. The court remanded the case to the trial court with directions to enter judgment in favor of the physician. The court said that she was entitled to back pay and to be hired as a staff physician. — *Joshi v. Florida State University Health Center*, 763 F.2d 1227 (C.A.11, Fla., June 21, 1985)

Preliminary Plans Announced For 118th Annual Session

The 118th Annual Session of the MSMA will get underway June 4 at the Royal d'Iberville Hotel in Biloxi.

Record numbers of physicians, their family members, and guests are expected to attend the five-day session, which this year occurs during summer vacation from most schools in the state.

Among special guests are entertainer Jerry Clower, who will be featured at the annual membership banquet on Friday, June 6, and AMA president Dr. Harrison L. Rogers, who will address the House of Delegates on June 5.

The annual meeting of the MSMA Hospital Medical Staff Section, at 1:30 p.m. on June 4, will kick off the combination scientific/business session. Speakers include J. Paige Clousson of Chicago, who will discuss issues facing the hospital medical staff, and Dr. Richard Thompson of Elmhurst, Illinois, who will speak on "Quality Assurance: Cost, Legal, and Ethical Issues."

The scientific program continues on Friday and Saturday with the Surgery and Medicine Plenary Sessions. Highlighting the scientific program will be presentation of the James Grant Thompson Memorial Lecture on Saturday. Dr. Don Gambrell of the Medical College of Georgia will discuss "Osteoporosis: Benefits and Risks of Estrogen-Progesterone Therapy."

Medical Assurance Company of Mississippi will hold its annual meeting on Friday afternon and the Mississippi Foundation for Medical Care will conduct its annual meeting on Thursday afternoon. More than a dozen medical specialty societies have also scheduled meetings during the week.

The annual President's Reception on Wednesday evening will mark the beginning of a week of social and fellowship events. Medical alumni organizations, including Ole Miss, Tulane and Millsaps, are among the groups which have scheduled functions during the week.

On the calendar of special activities are the annual two-day fishing rodeo and the golf and tennis tournaments. MSMA members are encouraged to sign up now for those events.

The MSMA Auxiliary will conduct its 63rd Annual Session during the week. A variety of special events are on the schedule.

The complete program for the 118th Annual Session will be printed in the May issue of JOURNAL MSMA.

Board Reviews Reports At Winter Meeting

The Board of Trustees held its regular winter meeting in Jackson on March 6 and handled an extensive agenda of business in preparation for the 118th Annual Session of the association to be conducted in June in Biloxi.

Among reports reviewed and acted on by the Board were the annual audit of the association and its subsidiaries, the Board's annual report to the House of Delegates concerning association operations and programs, the AMA delegates' reports and reports on legislation, scheduling of future annual sessions, operations of the *Journal MSMA*, the MSMA building program, the current HMO/IPA project, and the Prescription Abuse Data Synthesis (PADS) project.

In action regarding the MSMA building program the Board directed that plans proceed to offer a prospectus to finance the building through a limited partnership prior to the June annual session of the association. The offering will be limited to MSMA members on a first come, first serve basis.

The presidents of the Boards of the association-sponsored HMO/IPA met with the Board of Trustees to discuss the current status of the project. The Board heard how the project had exceeded its initial enrollment goals. A process for selection of a management plan to proceed with the project was reviewed by the Board.

On legislative matters dealing with efforts of the association for tort reform, the Board acted to appoint a committee to meet with committees of the Mississippi Trial Lawyers Association and the business community to discuss the professional liability insurance crisis and seek solutions to the crisis.

Based on action of the Board the Prescription Abuse Data Synthesis (PADS) project will be implemented in Mississippi with the association serving as liaison for the project. The project which is sponsored by numerous national medical organizations, including the AMA, seeks to address the

growing problem of diversion of prescription drugs from legal channels of supply.

The Board also heard reports from officers of the Medical Assurance Company of Mississippi, the Mississippi Foundation for Medical Care and the MSMA Auxiliary concerning activities and future plans of those organizations.

MSMA HMO/IPA Boards Selecting Management Plan

Plans are moving ahead on organization of an MSMA-sponsored HMO/IPA based on the project's exceeding its initial enrollment goal of 700 members on February 28.

The Boards of the HMO/IPA will begin meetings with management consultants this month leading toward selection of a business plan and staffing of the project. A key objective in this process will be to become operational as soon as possible. All management consultants selected for on-site presentations have extensive national experience in planning and operating HMO/IPAs.

While the management selection process is occurring, HMO/IPA membership recruitment activities will continue. During the second membership recruitment phase which will end May 31, stock in the HMO will be priced at $2,500 and the IPA participation fee will be $750. Effective June 1 the prices will be $3,000 and $1,000 respectively.

Mississippi and Georgia are no longer unique in their organization of statewide HMO/IPAs. The South Dakota Medical Association recently organized DAKOTACARE, a statewide HMO/IPA. The New Mexico Medical Society is considering offering an HMO/IPA product through an association-owned insurance company. The West Virginia Medical Society is in the process of organizing an IPA and the Tennessee and North Carolina medical societies will act on statewide IPA proposals at meetings this month.

PADS Program to Control Drug Diversion, Abuse

A program to curtail the diversion and abuse of prescription drugs will be implemented in Mississippi, under the direction of a coalition of state health agencies and health-related associations. The coalition was established at a meeting hosted by MSMA in late February.

Representatives of more than a dozen state organizations attended the introductory meeting and expressed intent to participate in the AMA's Prescription Abuse Data Synthesis (PADS) program. The MSMA will provide staff assistance for the project, and consultants from the AMA will lend technical advice. The coalition will arrive at specific goals and objectives, based on the magnitude of the problem in this state.

Nationally, the abuse of prescription drugs results in more injuries and deaths than all illegal drugs combined. According to the AMA, of the 1.5 billion prescriptions dispensed in the United States each year, several hundred million dosage units are diverted to illicit use. Furthermore, prescription drugs are involved in almost 60% of all drug-related emergency room visits and 70% of all drug-related deaths.

Most of the drugs are diverted from the more than half-million practitioners and pharmacies registered by the Drug Enforcement Administration and licensed by the states to provide health care to the American people. Although drugs are diverted at numerous points in the production and distribution chain, 80% to 90% of the diversion occurs at the hospital, practitioner and community pharmacy level.

The PADS model is based on a cooperative public/private sector approach, which has been demonstrated to be effective in combating the problem. The model is a product of the Informal Steering Committee on Prescription Drug Abuse, established in 1981 by representatives of 20 national organizations in medicine, pharmacy, government, industry and allied fields.

Organizations participating in the Mississippi PADS program are: Mississippi State Medical Association, Mississippi Pharmacists Association, Mississippi Board of Pharmacy, Mississippi Nurses Association, Mississippi Board of Nursing, Mississippi Hospital Association, Mississippi Department of Health, Mississippi Bureau of Narcotics, Mississippi Department of Public Safety, Mississippi Department of Mental Health, Mississippi Board of Medical Licensure, MSMA Disabled Doctors Program, Mississippi Board of Dental Examiners, Mississippi Medicaid Commission, and the Mississippi Attorney General's Office.

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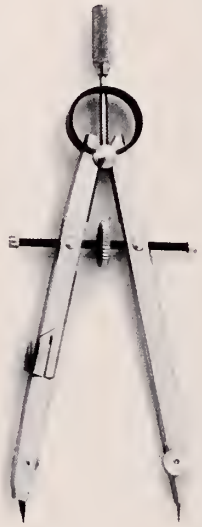
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PERSONALS

JAMES ACHORD of UMC spoke to the medical staff at Golden Triangle Regional Medical Center in Columbus.

MARILYN J. AIELLO of Marks announces the association of JOSE L. ROMAN for the practice of internal medicine.

ORLANDO ANDY of UMC recently made presentations at meetings of the Southern Neurosurgical Society in Boca Raton, Florida, and the Mississippi Academy of Science in Biloxi.

WILLIAM ASHFORD of Jackson spoke on refractive surgery and common dispensing problems at the annual meeting of the Mississippi Association of Dispensing Opticians.

G. CHRISTOPHER BALL has opened his office at 801 Northside Drive for the practice of obstetrics, gynecology and infertility.

G. WILLIAM BATES of UMC was visiting professor at Milwaukee Gynecological Society in Milwaukee, Wisconsin, in February.

CLAUDIA BEGHÉ of UMC made a poster presentation at the recent meeting of SREPCIM in New Orleans.

RICHARD BORONOW of Jackson is one of 15 Americans invited to join a committee to form an international multi-discipline society for the study of gynecologic oncology.

JOEL BRUNT of Pascagoula was speaker at Singing River Hospital's Community Health Education Seminar series on preventing heart disease.

CLAYTON COOK of Hattiesburg discussed detoxification of the chemically dependent patient at a seminar on alcohol and drug dependency at Pine Grove Recovery Center.

DAVID CRAWFORD of UMC lectured on diseases of the prostate in Lake Tahoe, Nevada, in February.

FRANK DAVIS of Corinth has been appointed by Governor Bill Allain to serve on the Tennessee-Tombigbee Waterway Development Authority's Planning and Development Committee.

CHARLES FRIEDMAN of Jackson spoke on "Group B Strep Sepsis and its Treatment" at a meeting of the Neonatal Nurses of Central Mississippi.

RODNEY E. FROTHINGHAM of Greenville has recently been promoted to the rank of colonel with the Mississippi Army National Guard.

HUGH GAMBLE of Greenville has been appointed by Governor Bill Allain to the Mississippi Emergency Services Advisory Council.

JAMES HARDY of UMC was guest speaker for Alpha Epsilon Delta at the University of Mississippi in Oxford.

CALVIN T. HULL of Jackson has been named chief of staff at Woman's Hospital.

MICHAEL E. JABALEY of Jackson was elected president of the American Society for Surgery of the Hand at its 41st Annual Meeting in New Orleans.

SAMUEL JOHNSON of UMC attended a board meeting of the Royal Maid Association for the Blind in Gulfport.

DON H. LAGRONE of Biloxi has been named a fellow of the American Academy of Pediatrics.

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PERSONALS/Continued

HERBERT LANGFORD of UMC was a site visitor at the University of Pennsylvania clinical research center in Philadelphia in February and also spoke at the Mississippi Academy of Science meeting in Biloxi.

C. FOSTER LOWE of McComb has been appointed by Governor Bill Allain to the Mississippi Emergency Services Advisory Council.

EDWARD M. LOWICKI of Jackson was featured speaker at Mississippi College's spring Social Science Forum. He spoke on hospice care for the dying.

ELDON D. MCCLAIN of Biloxi has been named chief of staff of Biloxi Regional Medical Center.

HUGH C. MCLEOD of Hattiesburg has been inducted as a fellow of the American Academy of Orthopaedic Surgeons.

GEORGE MCMULLAN of Jackson appeared on Channel 16's "Health Matters" program sponsored by Hinds General Hospital.

RICHARD MILLER of UMC attended a meeting of the test committee of the National Board of Medical Examiners in Philadelphia, Pennsylvania.

WILSON MOAK of Jackson spoke on common problems in children's vision at the annual meeting of the Mississippi Association of Dispensing Opticians.

C. M. MURRY of Oxford was guest speaker at a meeting of the Fellowship of Christian Athletes in Oxford.

WILLIAM NICHOLAS of UMC spoke on recent developments in diabetes at the mid-winter meeting of the Mississippi Pharmacists Association in Oxford.

JOE NORMAN of UMC presented a paper at the American College of Physicians meeting in Biloxi in February.

IVAN L. PEACOCKE of Hattiesburg discussed aftercare of the chemically dependent patient at a conference on alcohol and drug dependency at Pine Grove Recovery Center.

BRETT PERSON of Greenwood has been named to the board of directors of the Bank of Commerce.

G. O. RUNNELS and JAMES SABIN of Hattiesburg spoke at the Hattiesburg Psychiatric Group's seminar on anxiety.

VICTOR SALTER of UMC made a presentation at the American College of Physicians meeting in Biloxi.

ROBERT J. SCHMIDT of Biloxi has been named president of the medical/dental staff at Biloxi Regional Medical Center.

DOYLE P. SMITH of Hattiesburg was speaker at a Pine Grove Recovery Center conference on alcohol and drug dependency.

THOMAS E. STEVENS of Jackson has been appointed medical director of St. Dominic-Jackson Memorial Hospital.

EDSEL STEWART of McComb was the subject of a feature article in the *Enterprise Journal* which noted that he won the "best of show" award at the American Physicians' Artist Show in Orlando, Florida last fall.

EUGENE WOOD of Jackson has been named chairman of the Guardian Society of the University of Mississippi Alumni Association.

CORRECTION: The February issue contained an error. Dr. A. P. Soriano has opened his office for the practice of medicine in Pontotoc. He is not associated with Dr. Anita Batman, who is in solo practice.

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All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus*, volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

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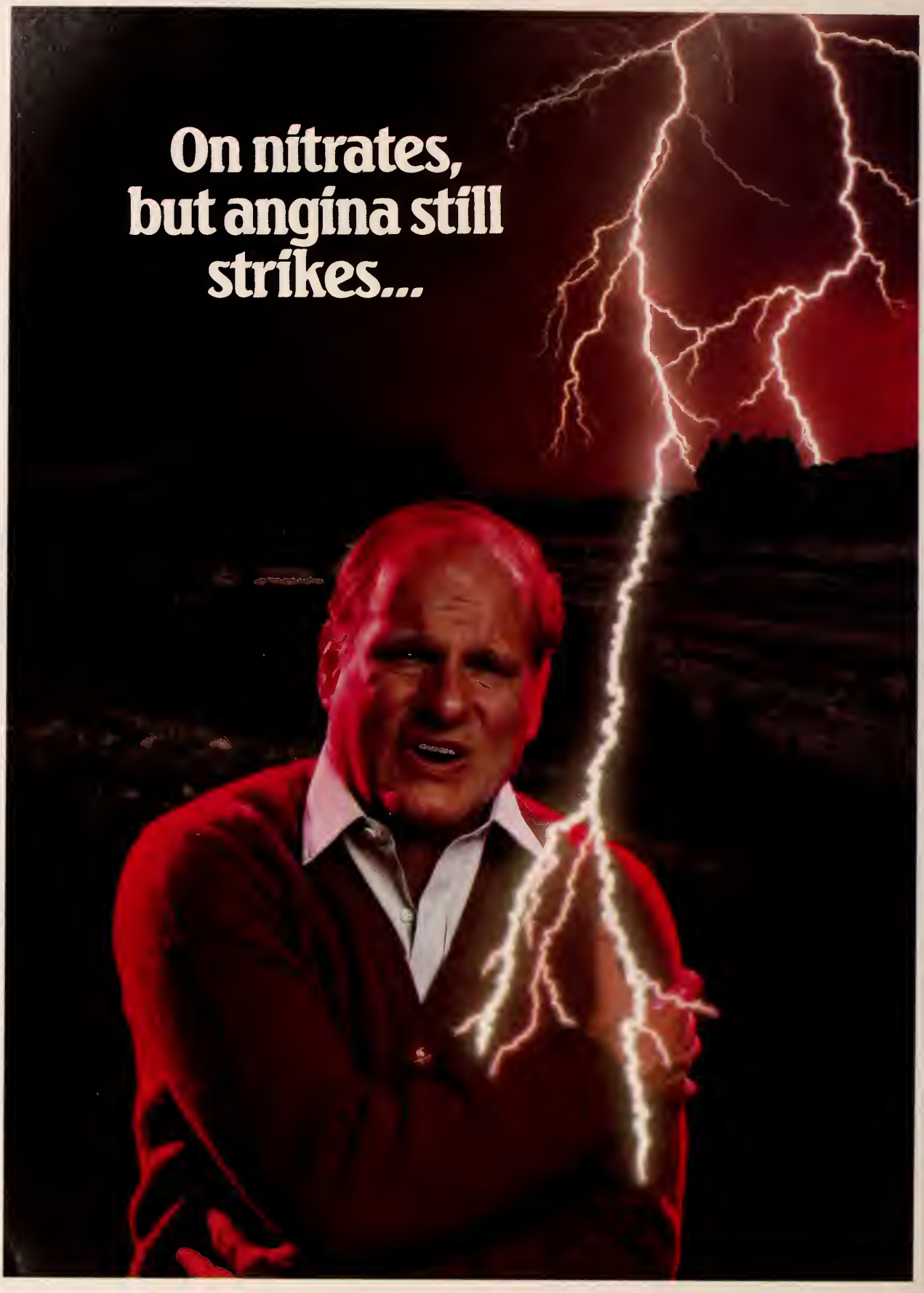
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Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C*: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. 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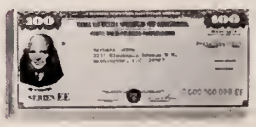


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MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 15-19, 1986, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

State and Local

Mississippi State Medical Association, 118th Annual Session, June 4-8, 1986, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, June 25-28, 1986, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, February, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, January, May, and November. H. S. Barrett, Secy., P.O. Box 1810, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington, Yazoo.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, Secy., Mail: Ms. Jenkins, P.O. Box 4053, Meridian 39305. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, Meetings scheduled quarterly. Fred G. Emrich, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, January. Charles S. Watras, 612 Summit St., Winona 38967. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, September, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. William Billington, Secy., 731 Medical Center Dr., West Point, MS 39773. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 1st Wednesday, February, April, June, August, October, December. John J. McCloskey, Secy., 3003 Short Cut Rd., Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. George R. Bush, Secy., 307 S. 13th Ave., Laurel 39440. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

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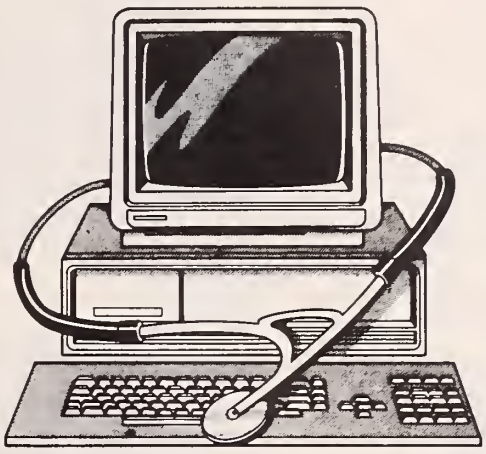
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Index to Advertisers

American Medical International 107
Avanti 111
Ayerst **10A, 10B, 10C, 10D**

Canton Exchange Bank 94
Curtis 1000 Information Systems 115

Deposit Guaranty Bank 108
Disability Determination Service 118

Harreld Chevrolet 99
F. Edward Hebert Hospital 10

Knoll Pharmaceuticals 112B, 112C, 112D

Le Bonheur Children's Medical Center 109
Eli Lilly and Company 95

Miss. Baptist Medical Center..... **8**
Medical Assurance Co. of Miss. **6**

MSMA Benefit Plan and Trust ..... **second cover**

Ochsner Hospital 88

Premier Printing 87

Roche Laboratories ..... **third, fourth covers**

Smith Kline and French 92B, 112A

University of Alabama **4, 5**
The Upjohn Company 92A
U. S. Air Force 114

Jon Wimbish 116

Thomas Yates & Co. **12**



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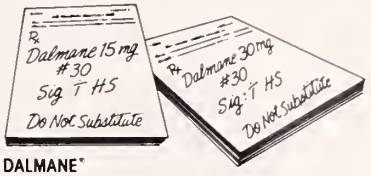
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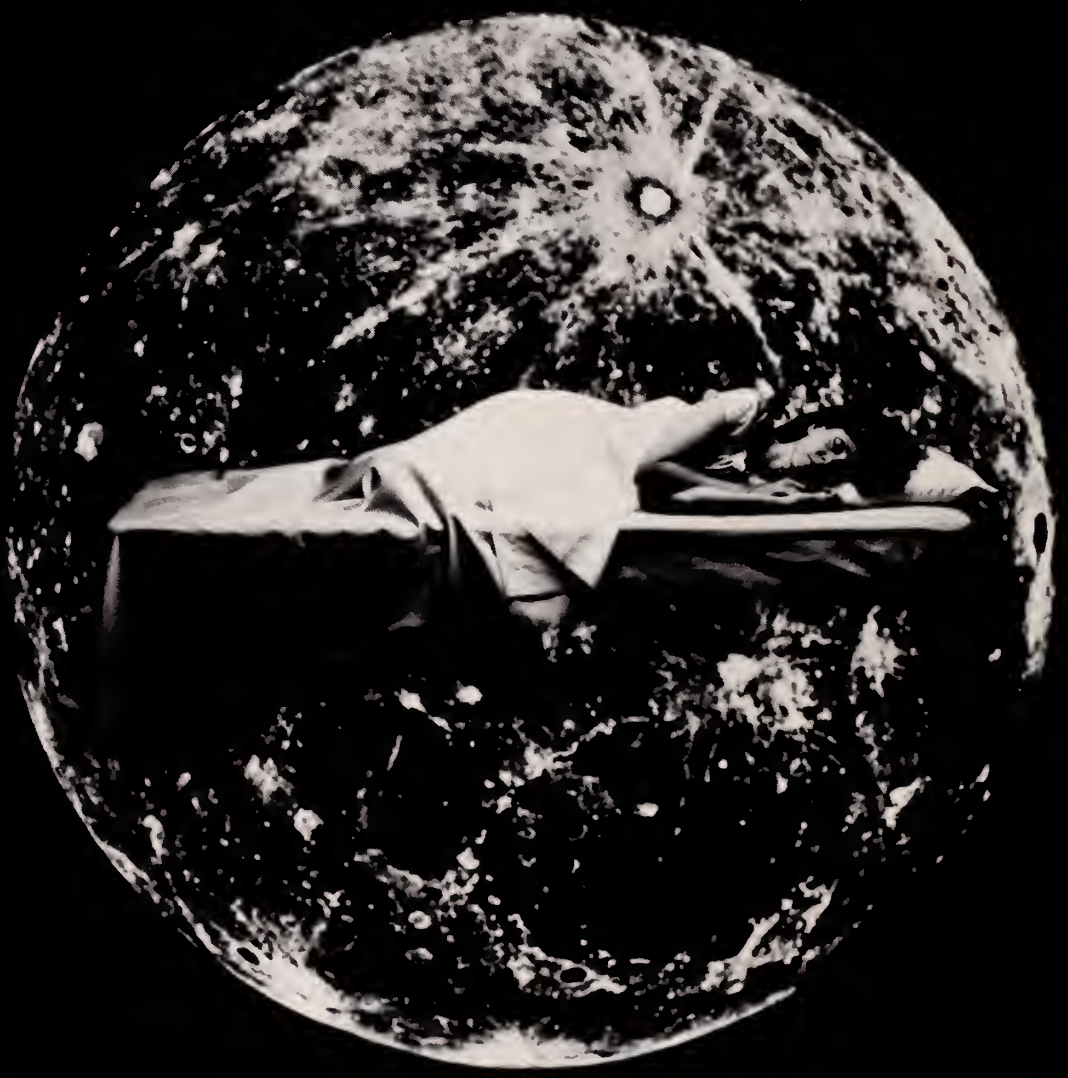
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JOURNAL of the MISSISSIPPI State Medical Association



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The Journal of the Mississippi State Medical Association is owned and published monthly by the Mississippi State Medical Association, founded 1856, at P.O. Box 5229, Jackson, Mississippi 39216. Subscription rate, $25.00 per annum; $35.00 per annum for foreign subscriptions; $2.25 per copy, as available. Advertising rates furnished on request. Printed by The Ovid Bell Press, Inc., Fulton, Missouri. Second-class postage paid at Jackson, Mississippi, and at additional mailing offices. POSTMASTER: Send address changes to Mississippi State Medical Association, P.O. Box 5229, Jackson, Mississippi 39216.

CONTENTS

ORIGINAL PAPERS

The Continent Jejunal Reservoir In Crohn's Colitis — **119** William O. Barnett, M.D.

Ob-Gyn Grand Rounds: Management of Menopause — **122** G. Rodney Meeks, M.D.

SPECIAL ARTICLE

118th Annual Session — **129** Preliminary Program

EDITORIAL

Rural Health Care Solutions Evasive — **127**

THIS MONTH

Back to the Future

126 The President Speaking
127 Comment
128 Medico-Legal Brief
133 Medical Organization
141 Personals
143 New Members

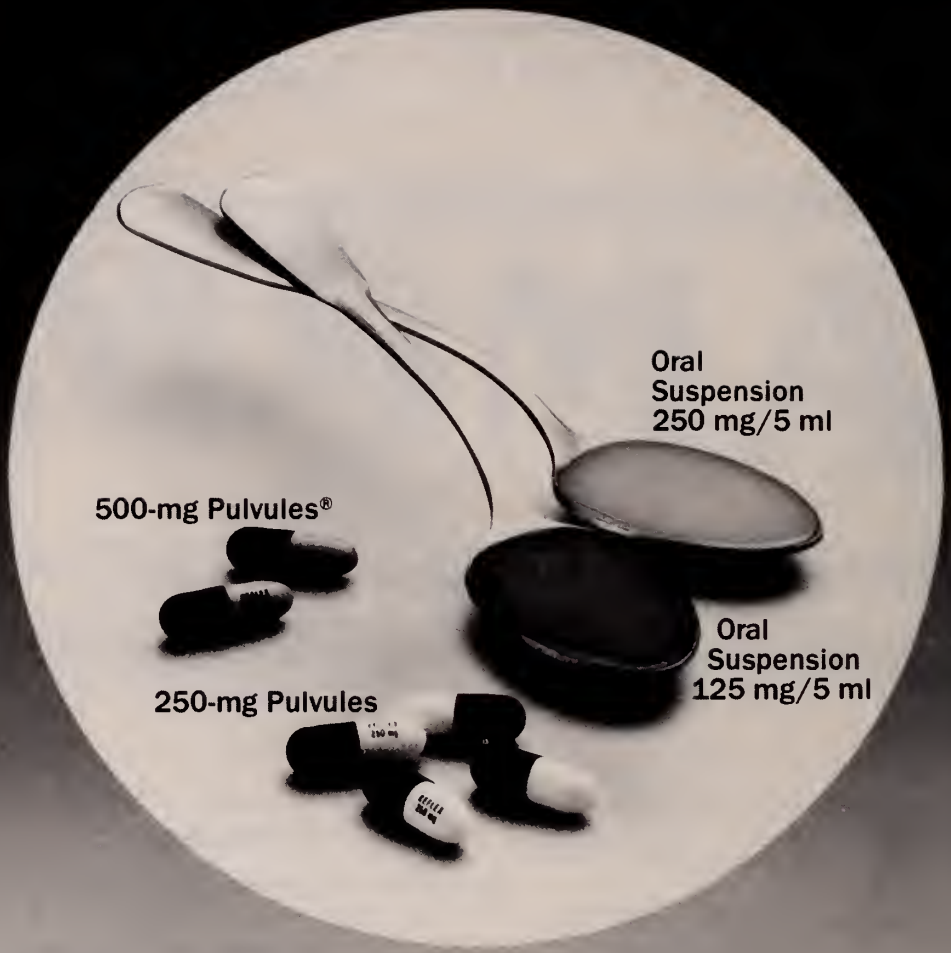
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May 1986

Dear Doctor:

Your MSMA headquarters is now located in downtown Jackson. At press time, staff was packing for the April 26 move to 236 East Capitol Street. These offices (the third floor of the Great Southern National Bank building) will house MSMA operations until construction is completed on the Riverside Drive complex, early in 1987.

The MSMA mailing address remains the same: P. O. Box 5229, Jackson 39216. Telephone numbers also are the same as before: 354-5433 (Jackson) and 1-800-682-6415 (WATS).

Previously, the Medical Assurance Company (professional liability insurer) moved to other headquarters. Their address is 220 Business Plaza, Suite B, 100 Business Park Drive, Jackson 39213. Telephone numbers for MACM are: 957-2855 (Jackson) and 1-800-325-4172 (WATS).

This issue of the Journal includes preliminary plans for the 118th Annual Session, June 4-8, in Biloxi. The Royal d'Iberville Hotel will again be the host facility. A number of speakers from across the country are scheduled to make presentations at meetings of the Hospital Medical Staff Section (Wednesday) and the scientific sessions (Friday and Saturday). The MSMA House of Delegates will hold two sessions, on Thursday and Sunday, and Dr. Harrison L. Rogers, AMA president, will be guest speaker. Featured entertainer for the annual MSMA/MSMA Auxiliary banquet is Jerry Clower.

The MSMA Auxiliary will hold its annual session during the week. Activities include the House of Delegates, the annual membership luncheon, and three workshops: flower arranging, financial planning, and self-defense.

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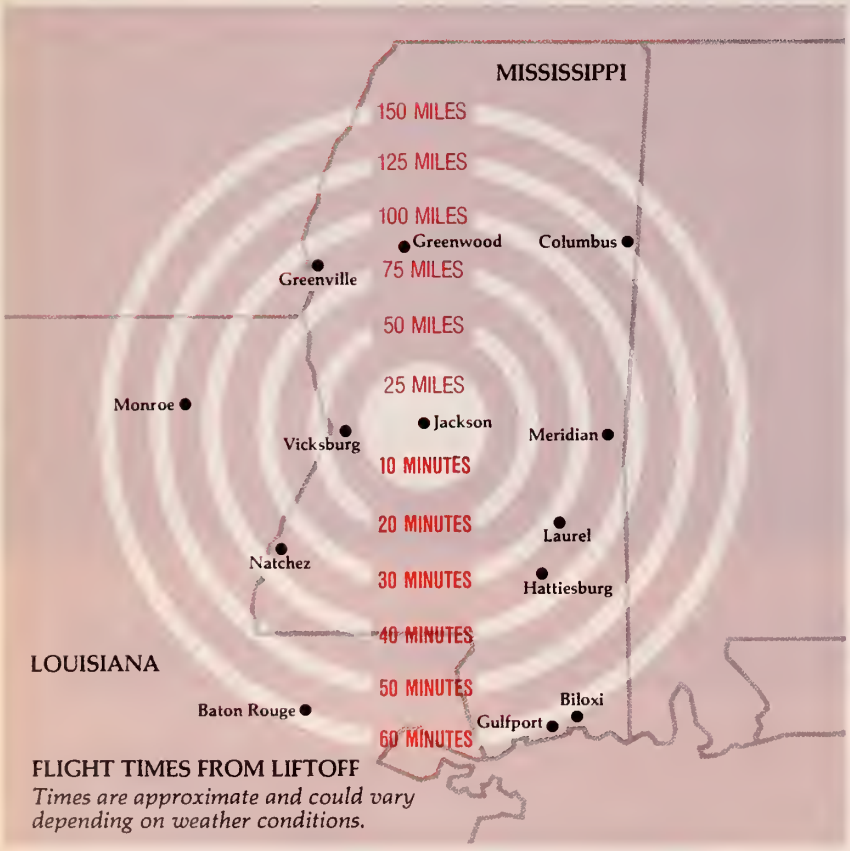
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DATELINE

Medicare Bankruptcy Date Moved Up

Washington, DC - Medicare's projected date with bankruptcy has been set at 1996, two years earlier than last year's estimate. In a report to Congress by the trust fund's board of trustees, it was noted that under the bleakest economic projections, the program could be bankrupt as early as 1993. Early corrective action was urged to bring the program into balance, specifically, a 22% reduction in spending or a 28% increase in income.

Medicare Deductible Will Increase Again

Washington, DC - 1987 will likely see another increase in Medicare's hospital deductible, which already rose by 23% for 1986. The success of the prospective payment system, ironically, is responsible. DRGs produced shorter hospital stays, which increased the average cost per day. Since the Medicare deductible is pegged to that figure, the deductible has gone up even as overall hospital costs have slowed.

No Gains in Fitness For American Youngsters

Washington, DC - The physical fitness of American youngsters has not improved in the last 10 years, and in some cases has greatly deteriorated. That was the finding of the President's Council on Physical Fitness and Sports. Commenting on long-term effects of poor physical fitness, the council urged a renewed emphasis on daily physical education in schools. Only 36% of American children now have such a program in their schools.

Drug Abuse, Mental Problems Not Properly Diagnosed

Chicago, IL - More than half of all patients with alcohol abuse, other drug abuse or mental problems obtain their medical care from primary care physicians, most of whom fail to diagnose, treat or refer such patients properly, suggests a report in the April 18 JAMA. Barriers to proper diagnosis and treatment include inadequate training in medical schools, patients' attitudes, and the constraints of the health care system.

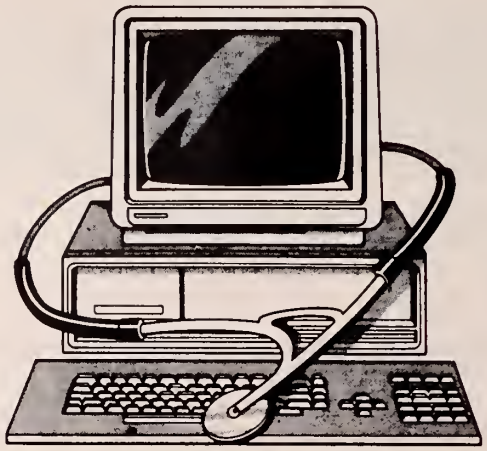
Search for Recipients Of AIDS-Contaminated Blood

Chicago, IL - The nation's blood collection agencies will begin a major effort to locate all patients who received transfused blood from donors later found to have antibody to the AIDS virus. The agencies will enlist the help of their members, hospitals, and physicians. They hope to identify nearly all recipients of possibly contaminated blood products and to eliminate future donations from antibody-positive donors.

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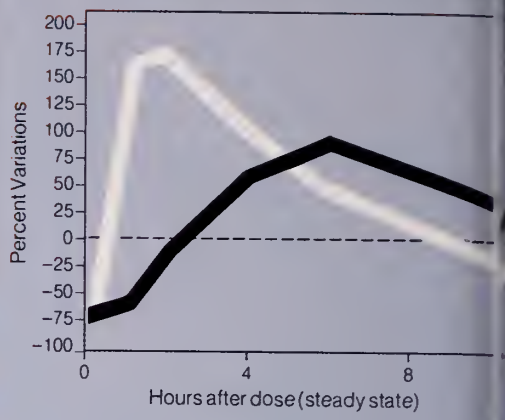
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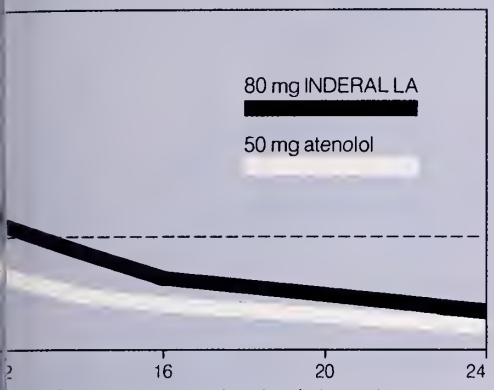
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CONTRAINDICATIONS

Propranolol hydrochloride (INDERAL® LA): Propranolol is contraindicated in: 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol.

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS

Propranolol hydrochloride (INDERAL® LA): CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated, and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely; or propranolol should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction following *abrupt* discontinuance of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA-BLOCKERS. INDERAL should be administered with caution, since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS

Propranolol hydrochloride (INDERAL® LA): GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. Propranolol is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that propranolol may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs, such as reserpine, should be closely observed if propranolol is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies, in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose. There are no adequate and well-controlled studies in pregnant women. Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: Propranolol is excreted in human milk. Caution should be exercised when propranolol is administered to a nursing mother.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

Hydrochlorothiazide: GENERAL: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely: Hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs irrespective of cause are: Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect of digitalis (eg, increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content.

Any chloride deficit is generally mild and usually does not require specific treatment, except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism, such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

DRUG INTERACTIONS: Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

PREGNANCY: Pregnancy Category C. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnancy requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

NURSING MOTHERS: Thiazides appear in human milk. If use of the drug is deemed essential, the patient should stop nursing.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL® LA): Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium; and decreased performance on neuropsychometrics.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation; mesenteric arterial thrombosis; ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash; fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis; nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes; dry eyes; male impotence; and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

Hydrochlorothiazide:

Gastrointestinal: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation; jaundice (intrahepatic cholestatic jaundice), pancreatitis; sialadenitis.

Central Nervous System: Dizziness, vertigo, paresthesias, headache, xanthopsia.

Hematologic: Leukopenia, agranulocytosis; thrombocytopenia; aplastic anemia.

Cardiovascular: Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity: Purpura; photosensitivity; rash, urticaria; necrotizing angiitis (vasculitis, cutaneous vasculitis), fever, respiratory distress, including pneumonitis; anaphylactic reactions.

Other: Hyperglycemia, glycosuria, hyperuricemia, muscle spasm; weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

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REFERENCES

1. Data on file, Ayerst Laboratories. **2.** Ravid M, Lang R, Jutrin I: The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily. *Arch Intern Med* 1985;145:1321-1323. **3.** Sumiye L, Vivian AS, Frisof KB, et al: Potassium loss associated with hydrochlorothiazide versus chlorthalidone. *Clin Ther* 1981;4:308-320. **4.** Ram CVS, Garrett BN, Kaplan NM: Moderate sodium restriction and various diuretics in the treatment of hypertension. *Arch Intern Med* 1981;141:1015-1019.

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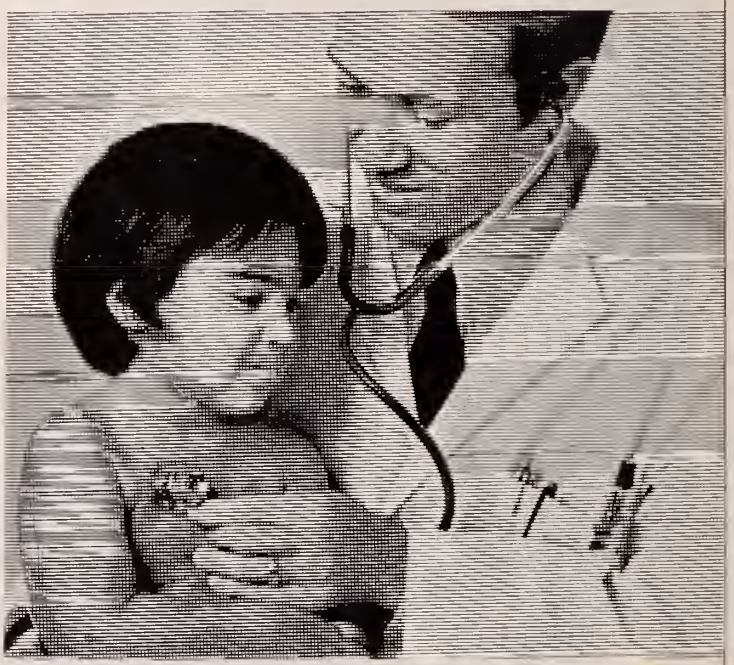
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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
May 1986, XXVII, Number 5

ORIGINAL PAPERS

The Continent Jejunal Reservoir In Crohn's Colitis

WILLIAM O. BARNETT, M.D.
Jackson, Mississippi

The attractiveness of providing a continent ileostomy for Crohn's colitis patients is lessened by the possibility of recurrent disease within the pouch. Jejunal tissue is much less likely to be involved if postoperative disease appears in the small bowel. The anatomical characteristics of the jejunum offers significant technical advantages when compared to the ileum. Resection of recurrent ileal disease could be followed by anastomosis of the normal proximal ileum to the jejunal pouch. Eight jejunal pouches have been constructed, three of which were among Crohn's colitis patients. To date, no significant problems have occurred.

THE INCIDENCE OF Crohn's disease appears to be increasing. It has been variously reported that the disease process involves only the colon in 10%[1] to 40%[2] of cases. Among these cases, the rectum was found to be involved in 50%[3] to 78%.[4] In cases where diffuse, granulomatous colitis exists and the rectum is also involved, it is generally agreed that coloproctectomy and ileostomy are in order.

Ileostomy for inflammatory bowel disease was first performed by Brown in 1912.[5] His crude pioneering technique was employed exclusively until 1952, when Brooke introduced the currently practiced method for ileostomy construction.[6] The Brooke ileostomy, for the first time, afforded an opportunity for the coloproctectomized patients to expect a reasonably healthy life with a lowered incidence of complications. In spite of highly developed surgical skills which are now available, the patient with a spout-type stoma continues to be faced with many problems.[7] The very presence of an uncontrollable, randomly discharging stoma implies that excrement must be collected and stored upon the body wall. The ever-present awareness of the continual soiling of oneself has been observed to activate formidable, negative emotional impacts.[8]

These circumstances have been operational in motivating increasing numbers of Crohn's colitis patients to explore the feasibility of acquiring a continent small bowel reservoir so that storage of intestinal waste and control of its discharge from the body can once again be restored.

Continent Ileostomy

The continent ileostomy currently represents a viable option for most patients following coloproctectomy for ulcerative colitis and familial polyposis. It is now well established that this operation provides a better quality of life under most circumstances. Our experience now includes 182 cases.

Dr. Barnett is engaged in the private practice of surgery in Jackson, MS.

Eighty-eight percent have necessitated no additional revision. The incidence of valve slippage, generally agreed to be the most troublesome complication, has been lowered to 2% in this series. Encouraged by these results, we have now embarked upon an investigation to consider the feasibility of providing a continent jejunal reservoir for highly selected Crohn's colitis patients.

Small Bowel Recurrence

The major concern attending a consideration of constructing a continent reservoir following coloproctectomy for Crohn's colitis relates to the possibility of recurrence of the disease process in the small bowel. This could result in pouch involvement by the disease process and thus necessitate its removal. We collected 465 cases from the literature where coloproctectomy had been necessary because of Crohn's disease involving the colon and rectum (see Table).

In all instances, there was no involvement of the small intestine at the time of the operation. Eighty-one (17%) subsequently developed small bowel recurrence. Recurrent small bowel disease is usually located in the ileum. In Goligher's large series, 90% of these recurrences were in the ileum, while only 10% involved the jejunum.[18] This circumstance brings forth the interesting consideration of constructing the continent small bowel reservoir from the jejunum rather than the ileum. This approach would provide a theoretical projected possibility of subsequent Crohn's disease recurrence in the pouch of 1.7% (17% × 10% = 1.7%) of cases. If a recurrence later developed in the lower ileum, the altered segment could be resected, following which the normal proximal bowel could be reanastomosed to the pouch. Of importance is the fact that the jejunum provides better tissue than the ileum for pouch and valve construction. The jejunum has a circumference three to four times the size of the ileum. The wall of the jejunum is thinner and more pliable. The jejunum mesentery is longer, thinner, more mobile and harbors less fat. These anatomical characteristics predispose to better technical circumstances attending pouch construction and can be expected to lower the rate of complications even further.

Construction of the Jejunal Reservoir and Valve

The distal jejunum is transected about where it joins the ileum. A purse string suture of 00 prolene is placed around the distal bowel. The proximal transected bowel is stapled closed. A suture is placed upon the antimesenteric surface of the proximal bowel 15cm above the site of transection. Adjacent 15cm loops are sewed together with 00 chromic catgut suture. The intestine is then opened around the horseshoe curve. An additional layer of continuous locked 00 catgut is placed upon the mucosa. The upper margins of the flat plate of intestinal tissue is then folded over. The superior margin of the pouch is closed with the TA90 stapling device. The proximal intestine is measured for a distance of 13cm. After the surface of the bowel is burned with the cautery, a segment of Gortex is laced through the mesentery. Four cm above, the jejunum is transected. A purse string suture is placed around the proximal bowel and this is anastomosed to the lower jejunum so as to bypass the pouch tissue. The proximal jejunum is than intussuscepted into the pouch for a distance of 5cm. Three rows of staples are placed around the valve with the SGIA. One end of the Gortex strip is then sutured to the side of the access segment with 000 cotton suture. The distal ileum is then stapled to the side of the pouch with the EEA stapler. An opening in the abdominal wall sufficient to accommodate two fingers is next made in the abdominal wall in the right lower quadrant. The access segment is passed through and the mucosa is sutured to the skin. The pouch is now sutured to the abdominal wall with interrupted prolene sutures. A catheter gastrostomy is routinely provided for postoperative gastrointestinal decompression (see Illustration).

TABLE 1

RECURRENCE OF CROHN'S DISEASE IN PATIENTS AFTER COLOPROCTECTOMYAND BROOKE ILEOSTOMY

Author	*Total No. Cases*	*Small Bowel Recurrence No. Cases*
Glotzer[9]	8	0
Nugent[10]	28	1
Howel Jones[11]	24	1
Ritchie[12]	64	4
De Dombal[13]	35	4
Steinberg[14]	73	24
Korelitz[15]	67	30
Goligher[16]	138	17
Himal[17]	28	0
Total	465	81 (17%)

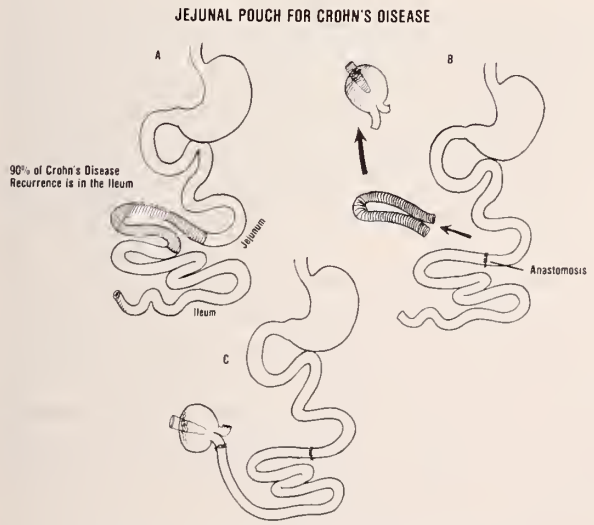
Selection of Cases

Where no bowel has been previously resected, a valid indication for coloproctectomy in the Crohn's patient must be established. With the exception of limited backwash ileitis, there must be no small

bowel involvement, either before or during the operation. Only highly motivated individuals who harbor a severe disenchantment with the presence of a conventional ileostomy will be included. The patients must also be informed and aware of possible small bowel recurrence of Crohn's disease which might necessitate future small bowel resection, regardless of the type of ileostomy that he might possess.

These patients who have previously had a coloproctectomy and who request conversion to a continent ileostomy must exhibit superior nutritional status. There must be no evidence of small bowel involvement or previous significant small bowel resection. Only highly motivated, intelligent patients should be accepted and they must be fully aware of possible small bowel recurrence which could require future bowel resection.

There is a small theoretical possibility (1.7%) that the Crohn's disease process could recur in the jejunal pouch. This might necessitate removal of the pouch with a loss of 22 inches of small bowel. The average small bowel length is 24 feet. The short bowel syndrome is a problem only after a loss of one-half (12 feet) of small bowel. If it becomes necessary to remove the pouch and valve, then the patient would have lost only about two feet of bowel and would have nine feet of small intestine remaining before achieving a loss sufficient to precipitate the short bowel syndrome.



Surgical technique currently employed.

Experience with The Jejunal Pouch

Occasionally the ileum is found to be unsuitable for pouch construction in ulcerative colitis patients because of small bowel caliber, mesenteric fat and rigidity of the bowel wall. In three such cases the valve and pouch were constructed from the jejunum. Among familial polyposis cases, mesenteric panniculitis may involve the ileum with resulting thickness and rigidity to such an extent that pouch construction is not possible. We have provided a continent jejunal reservoir for two familial polyposis patients who manifested these characteristics. Our experience also includes three cases of Crohn's colitis where a continent jejunal reservoir was constructed. Follow-up for these three cases is relatively short, but no problems have yet occurred. Thus, our total experience with continent jejunal reservoirs in all categories includes eight cases with satisfactory results to date. ★★★

603 Medical Towers (39216)

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Journal policy prohibits publication of more than ten references. For a complete bibliography, please contact the author.

Obstetrics and Gynecology Grand Rounds:
Clinical Case Management XI:

Management Of Menopause

G. RODNEY MEEKS, M.D., Moderator

Panelists: Ben L. Crawford, III, M.D., McComb, and A. Dean Cromartie, M.D., Hattiesburg.

DR. MEEKS: C.S. is a 36-year-old, gravida 2, para 2 married white woman whose last menstrual period was seven months ago. Her menses had been irregular with the flow alternating between light and heavy for two years. She had hot flashes, vaginal dryness and decreased libido. She noticed nervousness, anxiety and mood alterations. She had mild breast fullness and tenderness. Sleep disturbances were associated with night sweats and an increased awareness of dreaming.

Menarche had been at age 12. Her cycles previously had been monthly with 5 days of moderate flow. Her mother experienced menopuase at age 38 and her sister at age 40. The review of systems and past medical history were negative. Her husband had had a vasectomy.

This patient stood 55 inches and weighed 128 pounds. Her blood pressure was 100/80 mm Hg. The breasts were slightly tender and felt somewhat full. There was no galactorrhea. The vulva was normal in appearance with a female escutcheon. The vagina was pink, rugated and supple. The cervix was free of lesions and no mucus was present in the os. The uterus was normal size, mobile, anterior and nontender. The ovaries could not be palpated. The remainder of the general physical exam was unremarkable. What diagnoses should be considered?

From the Department of Obstetrics and Gynecology, University Medical Center, Jackson, MS.

DR. CRAWFORD: Pregnancy is the most common cause of secondary amenorrhea. Although her husband has had a vasectomy, vasectomies fail as do tubal ligations. Anxiety reactions, psychotropic drug therapy and marijuana use may alter menses. Pituitary failure, prolactin-producing tumors, and ovarian problems such as polycystic ovarian disease or ovarian tumors may lead to amenorrhea. Recent uterine surgery or severe endometritis may result in uterine synechia and in severe cases, amenorrhea.

DR. CROMARTIE: The most likely diagnosis is menopause, i.e. ovarian failure. Ovarian failure occurs in all women who live long enough. In the United States menopause occurs at approximately age 52. However, menopause may occur as early as age 35. This is particularly likely with a family history of early menopause.

DR. MEEKS: How significant a problem is menopause?

DR. CRAWFORD: This is probably the most common problem exclusive of pregnancy that I see. Indeed, epidemic numbers of women are becoming postmenopausal. The average life span of women is 81 years of age. This means that women will

spend fully one-third of their lives in a menopausal state.

DR. MEEKS: What are common problems of menopause?

DR. CROMARTIE: Well-documented problems include hot flushes, urogenital atrophy and osteoporosis. Many women experience nervousness, anxiety, irritability, mood changes, fatigue, insomnia and depression. These are not documented to be directly the result of estrogen deficiency. Some studies suggest that menopausal women are at increased risk for atherosclerosis, hypertension and coronary artery disease.

DR. MEEKS: What is the significance of the hot flush?

DR. CROMARTIE: Their sudden onset and unpredictable nature often lead to social embarrassment. As many as 85% of climacteric women may have hot flushes, and this in the most common symptom causing women to come to the physician. The sensation of warmth in the chest, neck, face and head is often accompanied by skin flushing, shivering and perspiration. Associated symptoms include lightheadedness, dizziness, headache, palpation and nausea. Fortunately these symptoms last only a few minutes and are usually mild. The hot flushes generally lessen in frequency, intensity and duration with advancing age.

DR. MEEKS: What urogenital changes are associated with menopause?

DR. CRAWFORD: Atrophy of the vaginal epithelium results in senile vaginitis often associated with irritation, burning, pruritis and vaginal bleeding. Atrophic changes in the urethra and trigone roughly parallel the changes seen in vaginal epithelium. With atrophy comes dysuria, frequency and cystitis.

DR. MEEKS: Does osteoporosis increase following menopause?

DR. CROMARTIE: Bone loss increases beyond the fifth decade of life in both men and women. The decline is much greater in women and is significantly associated with loss of ovarian function and the number of years beyond menopause or surgical castration. Osteoporosis presents perhaps the greatest hazard of menopause. Women experience a linear increase in the rate of forearm fractures and an exponental rate of increase in hip fractures following menopause. Vertebral body fractures occur in 25% of white women beyond the age of 65. The drain on our health resources is significant. In excess of one billion dollars was spent to treat hip fractures in 1976. Predicting which women will develop significant osteoporosis is difficult. Caucasian women who smoke, are slender, lose ovarian function at an early age, and have a significant family history form a high risk group.

". . . epidemic numbers of women are becoming postmenopausal. The average life span of women is 81 years of age. This means that women will spend fully one-third of their lives in a menopausal state."

DR. MEEKS: Do menopausal women experience significant psychological and psychiatric changes?

DR. CROMARTIE: No one has proven that menopause causes psychiatric illness. Environmental stress factors are unique to this age and may precipitate psychological or psychiatric disturbances. These factors include loss of a husband through death or divorce, loss of one or both parents and loss of children to college or marriage. The loss of reproductive capacity seems to be associated with a decreased feeling of femininity and a lowered self esteem. Factors which may modulate these symptoms include the age of menopause, her marital status, parity, occupation, educational level and income. Many would argue that these menopausal symptoms are a social role foisted on middle-aged women in Western society. However, some evidence does exist to show a direct relationship between estrogen and a lack of certain symptoms such as tension, anxiety and irritability. However, this may be related to the fact that estrogen relieves hot flushes, vaginal atrophy and sleep disturbances.

DR. MEEKS: Do menopausal women experience an increase in atherosclerosis?

DR. CRAWFORD: Following menopause the serum lipid profile is similar to that associated with an increase in atherosclerosis. With estrogen therapy low density lipoproteins can be decreased while high density lipoproteins can be increased, thereby producing a more favorable lipid profile. An actual decrease in myocardial infarction in postmenopausal women treated with estrogen has not been proven.

DR. MEEKS: How would one confirm the diagnosis of menopause?

DR. CROMARTIE: The diagnosis can be made on the basis of history and physical examination. A serum follicle stimulating hormone (FSH) concentration in excess of 30 mIU/ml would confirm the diagnosis.

DR. CRAWFORD: Certainly I would agree if this patient were 50 years of age. However, in this much younger age group additional problems might produce amenorrhea. I would first give the patient a

progestational agent to see if she would have a withdrawal period. This would confirm an estrogen level adequate to stimulate the endometrium. Additionally the FSH to LH ratio might be helpful in conditions such as polycystic ovarian disease or amenorrhea related to obesity. Alterations in thyroid function and hyperprolactinemia could be determined by obtaining thyroid stimulating hormone (TSH), thyroxine (T_4) and prolactin.

Dr. Meeks: Only a FSH was obtained for confirmation of diagnosis. The FSH concentration was 70 mIU/ml. How should menopausal women be managed?

Dr. Cromartie: Clearly menopausal patients can be separated into two groups. Those who are symptomatic and those who are asymptomatic. The symptomatic group is usually easier to manage because they have a symptom such as hot flush, dyspareunia, or vaginitis and they would like to have a remedy. The other group is more difficult, especially since a body of literature suggests osteoporosis (which is initially asymptomatic) is the most serious medical consequence of menopause.

"Progestational therapy decreases the relative risk of endometrial cancer in those who are receiving estrogen therapy. It does not interfere with the estrogen effect on osteoporosis and some studies have actually shown an increased bone formation with combination therapy."

Dr. Crawford: I believe that most menopausal women will benefit from estrogen replacement therapy. Both synthetic and natural estrogens relieve the symptoms of estrogen deficiency. Commonly utilized estrogen compounds are conjugated estrogens (Premarin), ethinyl estradiol (Estinyl), estradiol 17-beta (Estrace) and estrone and estropipate (Ogen).

Prevention of osteoporosis requires 0.625 mg of conjugated estrogen or its equivalent. In addition to prevention of osteoporosis, this amount of estrogen will usually reduce the number of hot flushes and reverse urogenital atrophy. As long as equivalent doses are utilized, there appears to be no advantage of one estrogen over the other.

Oral preparations are preferred. While vaginal creams may be appropriate in some instances, one must remember that they are absorbed and give systematic effect. Injectable long-acting estrogens and implants are not recommended because of the increased association of endometrial hyperplasia. On the horizon are topical estradiol ointments which may lead to a decreased toxicity because these compounds bypass the liver.

Dr. Meeks: This patient was started on estradiol (Estrace) 1 mg daily. She returned following one month of therapy and had dramatic relief of her symptoms. Are there risks to estrogen replacement therapy?

Dr. Cromartie: It now seems certain that endometrial carcinoma is related to estrogen. Certainly supplying exogenous unopposed estrogen leads to an approximately 2-4 fold increase in endometrial cancer as compared to those women who do not receive estrogens. Mild blood pressure elevation appears to be secondary to changes in the renin angiotensin system. The risk of cholelithiasis in increased approximately two-fold.

Dr. Meeks: What are contraindications to estrogen replacement?

Dr. Crawford: Absolute contraindications include undiagnosed vaginal bleeding, acute and chronic liver disease, vascular thrombosis and breast carcinoma. Relative contraindications include preexisting hypertension, uterine leiomyoma, hyperlipidemia, gall bladder disease, porphyria and cigarette smoking.

Dr. Meeks: Is there a role for progestational therapy?

Dr. Crawford: Progestational therapy decreases the relative risk of endometrial cancer in those who are receiving estrogen therapy. It does not interfere with the estrogen effect on osteoporosis and some studies have actually shown an increased bone formation with combination therapy. The beneficial effect of estrogen on the lipid profile may be altered with progestin. Medroxyprogesterone acetate seems to have less adverse effects than the others on the lipid profile. Women who have utilized estrogen and progestin in combination have recently been shown to be protected against breast cancer.

Dr. Meeks: How should the estrogen and progestin be given?

Dr. Cromartie: Estrogen should be given on days 1-25 of each month. The current recommendation is to add progestin on days 16-25. A major problem with this regimen is that most women who receive 0.625 mg conjugated estrogen or the equivalent (the dose necessary to prevent osteoporosis) are likely to have cyclic uterine bleeding. Some women find this unacceptable.

Dr. Meeks: How long should these women receive therapy?

Dr. Cromartie: The duration of therapy is con-

troversial. Certainly as long as a woman has symptoms she should receive therapy. For the hot flush this probably varies from one to five years. However, for the asymptomatic conditions such as osteoporosis, a good reference has not been established. Indeed it appears that once estrogen replacement is stopped, bone loss advances at its usual alarming rate.

DR. MEEKS: Is endometrial sampling necessary in women receiving estrogen therapy?

DR. CRAWFORD: If patients are on progestational therapy I do not do a yearly sample nor do I obtain a pretreatment endometrial sample. If I were treating a patient without progestin, I would perform a pretreatment sample and one yearly. Certainly any patient who has unscheduled bleeding should have an endometrial sampling.

DR. MEEKS: The consequences of menopause can be life-threatening and certainly area major health issue which demand attention. The "feminine forever" concept of the 60's has been tempered. Indeed a woman cannot be "forever young" and such attempts at remaining young are perhaps unwarranted in view of the aging process in other organs. However, epidemic numbers of women are entering menopause. Up to 85% of women will experience some menopausal symptoms. As many as 60% of women may benefit from estrogen replacement therapy, and some 25% of women will present for medical evaluation during their menopausal years. The question of whether all women should receive estrogen replacement therapy to protect those at risk of the consequences of menopause, especially osteoporosis, is controversial. Certainly more and more physicians are taking a forceful stand on estrogen replacement therapy. If not all, many women would benefit from estrogen replacement therapy in their menopausal years.

I would like to thank Dr. Cromartie and Dr. Crawford for taking time out of their practices and sharing their experience with us. ★★★

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Acknowledgement

Supported in part by the Vicksburg Hospital Medical Foundation.

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The President Speaking

Back To The Future

Ralph L. Brock, M.D.
McComb, Mississippi

The use of a time machine makes interesting speculation for a popular movie and a television commercial. I have also heard it predicted that some day we will be able to recover any sound ever made and be able to hear a voice speaking from centuries before. How many times have we said "if I had only known then what I know now." The past is very fascinating and studying history becomes more interesting as we get older, but I am not impressed with expressions such as "the golden years" and "the good old days." When it comes to the practice of medicine, I think our best years are yet to come.

I feel very fortunate in living at a time when dramatic progress has been made in medicine and patient care. I was 10 years old in 1935 when my dad came to lunch one day more excited than I could ever remember him. He had just treated his first case of pneumonia with sulfanilamide, and the patient was making a dramatic recovery. It made a lasting impression on me and is the only specific event I can remember from that year in my life.

Twenty years later, on April 12, 1955, I sat in a Jackson television studio and heard a closed-circuit announcement of the Salk Polio Vaccine. As a young physician and parent of two small children, I welcomed this protection made available against one of the most feared diseases. Four years earlier I had seen 30 cases of acute poliomyelitis in an open ward of a Flint, Michigan hospital. Today, Rotary International is leading an effort to rid the entire world of polio by the year 2005. We have seen smallpox eliminated in 1980, and I think it is within reason to expect more successes.

Many times I have been asked if I would recommend medicine as a career for a son or daughter. This time last year, I have to admit that I held a pessimistic view and did not really know what I would recommend. Many others have had the same pessimistic outlook because of several factors. Some feel that we are losing the close relationship with patients. Some are changing or stopping part of their practice because of the liability insurance crisis. Others feel that newer forms of hospital payments and profit motives will reduce quality of patient care. Recently I have noticed a more positive and optimistic attitude. More and more physicians are willing to join forces to fight for our profession

(Continued on page 146)

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XXVII, Number 5

MAY 1986

Doctor shortage:

Rural Health Care Solutions Evasive

The life of a young doctor in a small town can be rough.

The hours are long, the money shorter than in cities, in addition to a shortage of the entertainment and social advantages found in urban areas.

There are frequently no nearby specialists for consultation, hospitals without the equipment to which the physicians have come to depend, and often no one to take calls when the doctor wants a day off, much less take a long vacation.

The result, as noted in a story today, is often that towns like Moorhead, with its 1,000 people in the Delta, search in vain for a doctor willing to move to town.

Moorhead has not had a physician since 1981, when Dr. A. M. Phillips retired. Despite the offer of a free clinic and a built-in practice — Phillips reportedly made $150,000 in his last nine months from Moorhead residents alone — the town has been unable to attract a doctor.

This is not a new problem for Mississippi or rural areas elsewhere in the United States, but it is one that has defied solution despite a variety of efforts and a national surplus of doctors.

Harold Armstrong of the Mississippi Health Systems Agency says 45 counties in Mississippi have a medical manpower shortage to some degree.

The University of Mississippi Medical Center initiated a department of family medicine in 1973. Of its 86 graduates, 71 have remained in the state, with 55 percent of them practicing in communities with less than 10,000 people.

One program that has had some success is a state plan that grants medical students loans if they promise to practice in rural areas or at a state facility. Five years of rural practice can mean forgiving the entire $24,000 loan.

Perhaps some answers for towns like Moorhead might be found in the reasons cited by Dr. Ralph Brock, president of the Mississippi Medical Association and others that more doctors won't move into rural areas.

It could be easier to attract two doctors than one, if there were the right incentives and a population sufficient to provide the financial expectations of both. They could spell each other on weekends and vacations and provide a second medical opinion.

The problem is getting doctors into the areas in the first place. Once they are there for a few years, they likely will become enough a part of the community that they will be disinclined to move.

If communities can find ways to, in effect, guarantee young physicians the income to pay off their loans and provide the lifestyle they expect, such incentives would likely be unnecessary a few years down the road.

This is all easier said than done, but the availability of medical care is one of the most critical items in the survival and growth of small towns.

(Editor's Note: Reprinted from the March 9 issue of the *Clarion-Ledger/Jackson Daily News*.)

COMMENT

Not a Time to Retreat

Most of us who are involved in the practice of medicine have been affected by the activities of the Peer Review Organization, Mississippi Foundation for Medical Care, Inc. Sometimes this has resulted in frustration and irritation. Some feel that they would be happier if MFMC were not part of their lives. However, medical review is and will be part of the

foreseeable future. This is a time in which we physicians and medicine, itself:

—are scrutinized as a profession as never before by the public, politicians, and the media, often with unfavorable results;
—are having a dramatic explosion of knowledge which physicians are expected to master;
—are faced with more and more external factors that influence how physicians function and their relationship with each other, institutions, and outpatients.

I would like to suggest that we recognize MFMC as an organization which:

—is composed of physicians of various disciplines who understand the process of health care delivery;
—allows and encourages physician participation;
—can facilitate improved health care;
—addresses difficult issues of quality and appropriate utilization of limited resources;
—interacts with politicians and bureaucrats involved in designing and implementing health care policy.

This is not a time for us to retreat from involvement in the activities of the Peer Review Organization. We as physicians cannot afford to do that. Granted, there are many undesirable factors in the current system which we cannot change; however, there are numerous areas which can be changed. The challenges are great and the stakes are high for all of us. We need our best "thinkers" and the most knowledgeable health care professionals involved. We are responsible for making our system of health care the best it can be, and we should be unafraid of scrutiny from any quarter.

J. S. McIlwain, Jr., M.D.
Medical Director

Medico-Legal Brief

Arizona Court Awards Parents $1 Million For Loss Of Consortium

The parents of a child who suffered severe and permanent brain damage were entitled to damages for loss of filial consortium of their injured child, an Arizona appellate court ruled.

The 10-year-old patient was administered a dose of liquid cocaine, mistakenly thought to be liquid Tylenol. He suffered severe and permanent brain damage as a result of the mistake. In an action against several physicians, a trial court awarded him $5 million in damages and his parents $500,000 for past and future services to their son and $1 million for loss of consortium.

On appeal, the physicians did not contest the finding of liability, the damages awarded to the child's estate, or the award to the parents for services. Their sole issue was that loss of filial consortium was not a recognized cause of action in Arizona.

Affirming the trial court's decision, the appellate court said that the facts of the case illustrated a real loss of companionship with the injured child. The court noted that only a handful of other states recognized a cause of action for loss of filial consortium. The court said that recognizing a claim for loss of filial consortium due to negligence was a function for the courts, rather than the legislature. The court reviewed recovery under the Arizona wrongful death statute and said that recovery for loss of filial consortium should be allowed in negligence actions that do not result in the death of the victim.

The court noted that the loss of consortium claim was submitted to the jury by separate verdict because the trial judge recognized that it was an extension of the common law. In the future, the court said, such a separate verdict would be unnecessary and the claim for this damage would be only one element of the parents' damages.

The court affirmed the award of $1 million to the parents for loss of consortium of their son. —*Reben v. Ely*, 705 P.2d 1360 (Ariz.Ct. of App., March 25, 1985; rehearing denied, May 6, 1985; review denied, Sept. 4, 1985)

118th Annual Session

Mississippi State Medical Association

June 4-8, 1986

Biloxi

On June 4, 1986, the 118th Annual Session of the Mississippi State Medical Association will get underway. The combination scientific/business meeting will be held at the Royal d'Iberville Hotel in Biloxi. Reservations should be made directly with the hotel by completing the reservation cards mailed to MSMA members last month or by calling 388-6610 (Biloxi).

House of Delegates

Sessions of the House of Delegates are scheduled for Thursday, June 5 and Sunday, June 8. Both meetings will begin at 9:00 a.m. Dr. Harrison L. Rogers, president of the American Medical Association, will address the opening session. Delegates will also hear an address by Dr. Ralph L. Brock of McComb, MSMA president. The inauguration of Dr. W. Joseph Burnett of Oxford as 1986-87 president will take place during the final session.

Delegates will cast ballots for more than 80 nominees who have been selected by the Nominating Committee to fill nearly 30 vacancies in association offices. A list of candidates was mailed to all members 60 days prior to the elections, in accordance with the association's bylaws.

Concurrent Meetings

Among the many medical related groups which have scheduled meetings in conjunction with the annual session are the Mississippi Foundation for Medical Care and the Medical Assurance Company of Mississippi. The Mississippi State Board of Medical Licensure will meet during the week, as will more than a dozen specialty societies and four medical alumni organizations — Millsaps College, Tulane, University of Tennessee, and Ole Miss.

Scientific Assembly

Continuing medical education credit will be awarded for the scientific assembly, which begins Friday, June 6, with the Surgery Plenary Session and continues Saturday, June 7, with the Medicine Plenary Session. The Mississippi Chapter of the American College of Surgeons will hold a three-hour scientific session on Friday, as will the Mississippi Chapter of the American Academy of Emergency Physicians. Highlighting the scientific presentations will be Dr. Don Gambrell of the Medical College of Georgia (Augusta), who will present the sixth annual James Grant Thompson Memorial Lecture on Saturday morning.

Special Events

Jerry Clower will be the featured entertainer at the annual MSMA/MSMA Auxiliary banquet on Friday evening. Members and guests will have the opportunity to greet association officers at the President's Reception on Wednesday evening.

Tennis, golf and fishing are on the agenda of special events again this year. Members are urged to sign up now for these popular events.

OFFICIAL CALL

To all members of the Mississippi
State Medical Association:

The 118th Annual Session of the Mississippi State Medical Association is called to meet at Biloxi, Mississippi, on Wednesday, June 4, 1986, pursuant to Article V of the Constitution. The House of Delegates will be convened at the Royal d'Iberville at 9:00 a.m. on June 5.

The Scientific Assembly will meet during June 6-7, 1986.

No member or guest will be permitted to participate in any aspect of the annual session until regularly registered.

RALPH L. BROCK, M.D.
President

J. ELMER NIX, M.D.
Secretary-Treasurer

SCIENTIFIC PROGRAM

118th Annual Session

Friday, June 6
MSMA Plenary Session (Surgery)

8:00 a.m. **Pre-Hospital Emergency Medical Education**
Robert C. Jorden, M.D., University Medical Center, *Jackson*

8:30 **Mississippi Surgery: Back Then, Today and Tomorrow**
James D. Hardy, M.D., University Medical Center, *Jackson*

9:00 **AIDS in the O.R.**
William A. Causey, M.D., *Jackson*

9:50 **No-No's in Medicine**
Tom L. Stennis, II, LL.B., *Gulfport*

10:30 **The Collard Green Connection**
James L. Hughes, M.D., University Medical Center, *Jackson*

Friday, June 6
American College of Surgeons, Miss. Chapter

11:00 a.m. **Clinical Studies in Acute Pancreatitis**
Harlan Stone, M.D., University of Maryland, *Baltimore*

12:00 Luncheon

1:30 **Changing Concepts in Surgical Infection**
Dr. Stone

2:30 **Trauma Lecture: Immediate Surgery for the Poly-Traumatized Patient — Yes or No?**
Felix Savoie, M.D., University Medical Center, *Jackson*

Friday, June 6
American College of Emergency Physicians, Miss. Chapter

1:00 p.m. **ACLS Update and Radiologic Emergencies**
William W. Bradford, M.D., *Waveland*

Saturday, June 7
MSMA Plenary Session (Medicine)

8:35 **James Grant Thompson Memorial Lecture — Osteoporosis: Benefits and Risks of Estrogen-Progestogen Therapy**
Don Gambrell, M.D., Medical College of Georgia, *Augusta*

9:15 **Hypertension Therapy: Rationale for Drug Selection**
William Cushman, M.D., University Medical Center, *Jackson*

10:10 **Radiology Update: MRI — Current Status and Future Promise**
Kenneth Miller, M.D., Oschner Clinic, *New Orleans*

10:25 **Dermatology Update: News You Can Use in Your Practice**
Louis J. Wise, Jr., M.D., *Jackson*

10:40 **Family Practice Update: Flexible Sigmoidoscopy — Training, Credentialling, and Utilization Criteria**
Isaac Aultman, M.D., *Jackson*

11:05 **Pediatric Update: Evaluation of Recurrent Abdominal Pain in Children**
Paul H. Parker, M.D., University Medical Center, *Jackson*

11:20 **Psychiatry Update: Choosing the Appropriate Antidepressant Medication**
Howard Freeman, M.D., *Jackson*

11:35 **Preventive Medicine Update: Acquired Immunodeficiency Syndrome (AIDS)**
F. Ed Thompson, M.D., Miss. Department of Health, *Jackson*

Abstracts — 118th Annual Session

Evaluation of Recurrent Abdominal Pain in Children

(Paul H. Parker, M.D.)

The evaluation of a child or adolescent with recurring abdominal pain can be a taxing clinical ordeal for the primary care physician, consultant, patient, and the family. The majority of children with this problem do not have serious underlying organic pathology present. However, the physician is often compelled to investigate these patients extensively in order to: (1) avoid missing a true organic problem and (2) relieve the patient's and family's anxiety concerning the problem.

A detailed history and complete physical examination are essential in the evaluation of these patients. While functional problems may mimic organic lesions very closely, certain clues should alert the physician to underlying physical problems. These include: nocturnal pain, diarrhea or vomiting, significant weight loss or failure to thrive, unusual rashes, joint complaints, unexplained fevers, oral ulcers, gastrointestinal bleeding, non-periumbilical pain, and a family history of certain gastrointestinal lesions.

The routine diagnostic evaluation of a child with recurrent abdominal pain should include: complete blood counts, sedimentation rate, amylase, liver function tests, urinalysis and culture, stool examinations for viruses, bacteria or parasites, and occult blood. More extensive diagnostic studies are usually directed by the history, physical examination and routine laboratory studies. These may include: plain and barium radiographs of the gastrointestinal and genitourinary systems, ultrasonography, computerized axial tomography, hydrogen breath analysis, electroencephalography, toxicologic determinations, and various endoscopy procedures. Finally, the empiric use of well defined treatment plans may serve both a diagnostic and therapeutic function. A practical plan for evaluating the child with recurrent abdominal pain, and an update on some of the more recent diagnostic modalities will be presented.

Hypertension Therapy: Rationale for Drug Selection

(William C. Cushman, M.D.)

A variety of factors can be taken into account when selecting among the many antihypertensive agents available today. Some theoretical factors must be distinguished from those that are of proven clinical importance. Among those that may be important include predicted efficacy, experience (e.g. in morbidity/mortality trials), convenience, cost, adverse effects, contraindications, and concommitant indications.

Diuretics are of proven value as initial therapy for many patients and should be included in almost any multidrug regimen. In relatively compliant hypertensive patients, blood pressure can be normalized 50-70% of the time with one of several classes of agents (as monotherapy), 80-90% of the time with two-drug regimens (that include a diuretic) and close to 95% of the time with certain three-drug regimens. A drug that produces significant adverse or side effects or appears ineffective in an individual patient may be replaced with an alternative antihypertensive agent.

MRI: Current Status and Future Promise

(Kenneth D. Miller, M.D.)

The clinical application of nuclear magnetic resonance to medical imaging as Magnetic Resonance Imaging (MRI) has provided a powerful new diagnostic tool. The MRI system uses a strong, uniform magnetic field to align the atomic spins of the atoms to be studied, normally hydrogen. A radiofrequency (RF) signal of proper frequency is used to rotate the spins of the atoms to be measured away from their equilibrium direction. When the RF signal is turned off, the atoms realign with the magnetic field and emit a radiofrequency signal which may be measured. By complex circuitry and utilizing a computer, ultimately an image is produced. MRI has an advantage over computed tomography in that images may be easily obtained in axial, coronal, saggital or paraxial planes of section.

The presentation will stress the clinical application of MRI imaging especially at the current state of the art with some discussion of possible future developments. The areas of cost and cost efficiency will be discussed as well as stressing the apparent strengths and weaknesses of the imaging modality.

Material will be presented to demonstrate normal anatomic structures delineated by MRI and representative case material will be shown encompassing CNS, spine, chest, cardiac, abdomen, pelvis and musculoskeletal disease as evaluated by MR imaging.

No-Nos in Medicine
(Tom L. Stennis, LL.B.)

Among Nos-Nos which will be discussed are:

*1. Never change your office or hospital records.
2. Never talk with anyone, especially an attorney, without knowing all of the facts and the issues relative to the medical situation.
3. Never chart thought processes or opinions without all the facts.
4. Do not use "words of relativity" in charts.
5. Never chart a "rule out," "working," or "possible" diagnosis without (a) within reasonable probability ruling the diagnosis out, of (b) treating it.
6. Never fail to exercise good bedside manners and good working relationship with other physicians and nurses.
7. Never guarantee a result.
8. Never fail to encourage a patient to obtain a second opinion.
*9. Never conceal a mistake.
10. Never allow anesthesia to be performed in your office.
11. Never fail to provide informed consent.
12. Never speak with an attorney who is not your personal lawyer, without superior knowledge of the medical records and medical issues.
13. Never make your general medical judgment absolute for every situation.
14. Do not gossip.

A discussion of a current legal/medical problem will be provided:

a. Mississippi's Rules of Evidence as applied to Peer Review Committees;
b. Disciplining a below-minimal standard physician and then being accused of restraint of trade and anti-trust.

Quality Assurance:
Cost, Legal, and Ethical Issues
(Richard E. Thompson, M.D.)

Quality assurance is a term we should stop using. It is, at the same time, too nebulous yet too strict a guideline. The better guideline is "accountability." We are accountable for being:

- Effective practitioners — How do patients do?
- Efficient practitioners
- Available and accessible
- With an appropriate attitude toward patients, peers, and co-workers.
- Aware of the importance of the patient's medical record from the combined standpoints of patient care, legality, and cost issues.

The basic need is for overhauled methods of "peer review" and "credentials" responding to these requirements.

Innovative new methods will be demonstrated.

Pre-Hospital Emergency Medical Education
(Robert Jorden, M.D.)

Training of prehospital care personnel in Mississippi occurs at basic, intermediate and advanced levels. While most basic EMT's are trained at junior colleges, advanced personnel receive their education through programs offered by emergency medical services (EMS) districts or the University of Mississippi Medical Center. Renewed interest in providing advanced life support in several areas of the state has created an increased demand for training. As a result, more students are currently enrolled in training programs than at any other time.

Training is extensive and intense, covering nearly all emergencies over a 12-month time frame. Approximately 1000 contact hours are required during this period with classes meeting two to three times per week. Instruction, which includes didactic, laboratory and clinical exposure, emphasizes assessment and interventional skills aimed at stabilizing the critically ill and injured. These individuals with limited medical backgrounds are thus transformed into physician extenders capable of sophisticated resuscitative measures.

Provided they can overcome the present funding difficulties, the training programs will continue to provide an important public health service by producing quality paramedics. The long term success of both the training and implementation phases of advanced prehospital care, however, rests with ongoing physician involvement.

MSMA Membership Banquet Features Jerry Clower



Entertainer Jerry Clower will bring his special brand of humor to the MSMA's 118th Annual Session in Biloxi. Clower, known as "the mouth of the Mississippi," will be the featured speaker at the annual MSMA/MSMA Auxiliary Membership Banquet Friday, June 6.

Hospital Medical Staff Section Schedules Second Meeting

The second annual meeting of MSMA's Hospital Medical Staff Section will take place at 1:30 p.m., Wednesday, June 4, at the Royal d'Iberville Hotel in Biloxi.

Scheduled in conjunction with MSMA's 118th Annual Session, the meeting is designed to serve as a forum for discussion of hospital medical staff issues. Physicians and hospital administrators are urged to participate.

The program includes discussions by Richard E. Thompson, M.D., of Elmhurst, Illinois, and J. P. Clousson of Chicago. Dr. Thompson's topic will be "Quality Assurance: Cost, Legal and Ethical Issues." Mr. Clousson, president of Physician Support Services, Inc., will present "Hospital Medical Staff/Hospital Management Relationships in the Health Care Industry — How Sophisticated Are They?"

Participants will also hear an update on MSMA's HMO/IPA. Dr. John D. Morgan of McComb, chairman of the Hospital Medical Staff Section, will preside.

Tennis, Golf, Fishing Events On Annual Session Calendar

Registration is underway for MSMA's tennis tournament, golf tournament, and deep sea fishing rodeo. All three events are on the schedule of activities for the 118th Annual Session in Biloxi.

The tennis tournament, sponsored by the Medical Assurance Company of Mississippi, is set for Saturday, June 7, at Hiller Park Courts in Biloxi. Matches will begin at 1:00. Trophies will be awarded in men's and women's doubles competition. Tennis balls and refreshments will be provided.

Golf tournament participants will gather at the Sunkist Course at 12:00 noon, Friday, June 6. Trophies will be presented for low gross and low net scores. Prizes will be awarded for longest drive and closest to the pin. Registration is limited to 48 golfers.

Two of the Gulf Coast's finest charter boats have been reserved for the fishing rodeo, set for Friday and Saturday, June 6 and 7. Boats will leave from the Broadwater Marina at 7:00 a.m. and return at 3:30 p.m. The $70.00 registration fee covers boat rental for the day, soft drinks and sandwiches. Prizes will be awarded for largest catch in Spanish mackerel, bonito and jackfish.

AMA President Will Address House of Delegates



Harrison L. Rogers, Jr., M.D., president of the American Medical Association, will address the MSMA House of Delegates on Thursday, June 5.

Dr. Rogers, a general surgeon from Atlanta, became AMA president at its annual meeting in 1985, after serving as Speaker and Vice Speaker of the AMA House of Delegates. Long active in the Medical Association of Georgia, he served in many capacities including Vice Speaker and Speaker of its House of Delegates, member of the Board of Trustees, and recipient of the Distinguished Service Award.

118th Annual Session

June 4-8, 1986

Summary of Activities

Wednesday, June 4
- MSMA Hospital Medical Staff Section
- MSMA President's Reception

Thursday, June 5
- Reference Committee Breakfast
- MSMA House of Delegates
- Miss. Foundation for Medical Care
- Miss. State Board of Medical Licensure
- Reference Committee Hearings
- Medical Alumni Reunions

Friday, June 6
- Fishing Rodeo
- MSMA Past President's Breakfast
- MSMA Plenary Session (Surgery)
- MSMA Fifty Year Club
- Miss. EENT Association
- Miss. Ob-Gyn Society
- American College of Surgeons
- American College of Emergency Physicians
- Miss. Internal Medicine Society
- Miss. Anesthesiology Society
- Medical Assurance Co. of Miss.
- Golf Tournament
- MSMA/MSMA Auxiliary Membership Reception and Banquet

Saturday, June 7
- Fishing Rodeo
- MSMA Plenary Session (Medicine)
- Miss. Academy of Family Physicians
- Miss. Pathology Association
- Miss. Dermatology Society
- Miss. Urology Society
- Miss. Academy of Pediatrics
- Miss. Orthopedic Society
- Tennis Tournament

Sunday, June 8
- Continental Breakfast
- Protestant and Catholic Services
- MSMA House of Delegates

Silent Auction Will Benefit AMA-ERF

MSMA and MSMA Auxiliary members and guests at the 118th Annual Session will have an opportunity to purchase attractive items and benefit AMA-ERF at the same time.

According to Mrs. Ben Martin (Linda), 1985-86 president of the MSMA Auxiliary, a silent auction will be conducted during the reception that precedes the annual membership banquet on Friday, June 6, at the Royal d'Iberville Hotel. A number of objects have been donated for the event. Contributions will be tax-deductible.

Fifty Year Club Will Meet June 6

The MSMA Board of Trustees, sponsor of the association's Fifty Year Club, will honor the half-century-plus members at a special luncheon on Friday, June 6, at the Royal d'Iberville Hotel.

Members of this special organization include: Drs. S. Lamar Bailey of Kosciusko; T. J. Barkley of Belzoni; Eldon Bolton of Biloxi; Sam B. Caruthers of Grenada; J. T. Davis of Corinth; J. Gordon Dees of Jackson; G. Swink Hicks of Natchez; Stanley Hill of Corinth; Joseph Kuljis of Biloxi; Julius L. Levy, Sr., of Clarksdale;

Earl L. Laird of Union; Lawrence W. Long of Jackson; Veronica M. Pennington of Jackson; A. R. Perry of Natchez; Tom Ramsay of Biloxi; Lee R. Reid of Jackson; G. T. Sheffield of Gulfport; Omar Simmons of Newton; Guy T. Vise, Sr. of Meridian; Earl T. White of Greenville; and Homer A. Whittington of Natchez.

James Grant Thompson Memorial Lecture

Saturday, June 7 **8:35 a.m.**

Osteoporosis: Benefits and Risks of Estrogen-Progestogen Therapy

Don Gambrell, M.D., professor of obstetrics and gynecology, Medical College of Georgia, Augusta.

Motrin® 800 mg TABLETS
ibuprofen

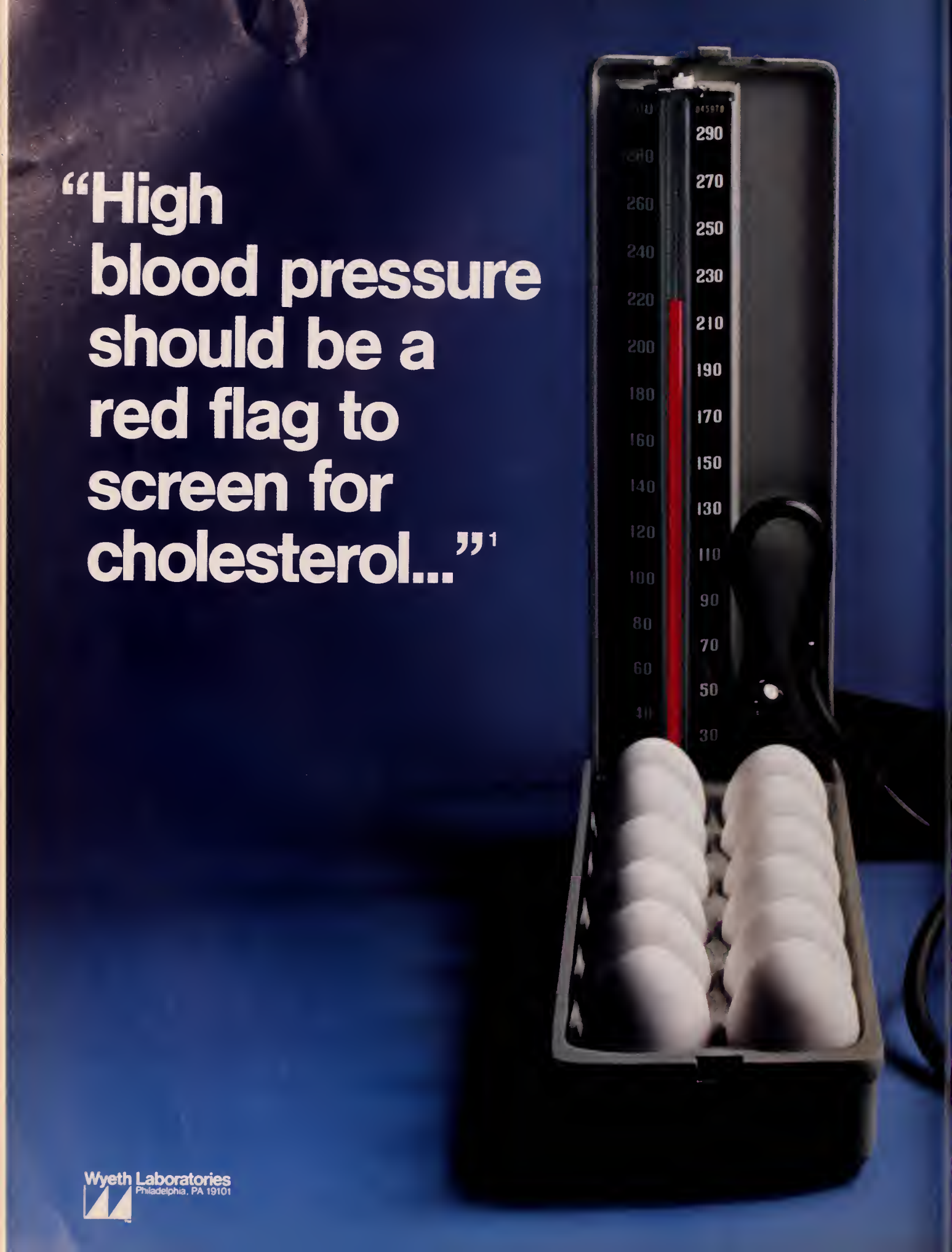


Extra strength
Convenience
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J-6138 January 1986



Wyeth Laboratories
Philadelphia, PA 19101

If your patients have hypertension, they probably have high cholesterol too.

The Framingham Heart Study[2] showed that over two thirds of the 35 and older population in that study with systolic blood pressures over 145 mmHg also had serum cholesterol levels of 225 mg/dL or more, and 46% had levels above 250 mg/dL.

While many clinical laboratories still report 250 mg/dL as "normal" cholesterol, the NIH Consensus Development Conference Statement on Cholesterol and Heart Disease[3] stated that any level above 220 mg/dL is associated with a significantly increased risk of coronary heart disease.

You need to know, because high cholesterol parallels high blood pressure as a CHD risk factor.

Epidemiological studies and large-scale prevention trials have indicated that as with blood pressure, serum cholesterol levels are proportionately related to CHD risk.

Specifically, *"...for every 10 mmHg rise in pressure, there appears to be about a 30% rise in cardiovascular risk."*[4] *"...for every one percent you go up the American cholesterol scale, your subsequent rate of heart attack rises two to three percent."*[5]

And although the specific impact on CHD has not been determined, we know that many of the principal agents used to lower blood pressure actually increase cholesterol.

Wytensin® lowers blood pressure effectively without raising cholesterol.

While Wytensin is not a cholesterol-lowering agent and is not indicated for the treatment of hyperlipidemia, in controlled clinical trials[6] it caused a slight, sustained decrease in total cholesterol without reducing the HDL fraction or altering serum triglycerides.

At the same time, Wytensin lowered blood pressure as effectively as hydrochlorothiazide, propranolol, clonidine or methyldopa. Drowsiness and/or dry mouth, the most frequent side effects noted with Wytensin, usually diminish or disappear over time. In fact, in double-blind studies to date, discontinuance of therapy for all side effects occurred in about 13% of patients.



WyTensin®
(guanabenz acetate)

Antihypertensive therapy that does not increase cholesterol

See important information on following page.

References: 1. Glueck CJ: Remarks in the symposium, *Blood Pressure, Cholesterol and Coronary Heart Disease*, Washington, D.C., March 31, 1985. 2. *The Framingham Study, An epidemiological investigation of cardiovascular disease*, Section 28, U.S. Dept. of Health, Education, and Welfare. 3. National Institutes of Health Consensus Development Conference Statement, 1984: Vol 5, No 7, p 4. 4. Chobanian AV: The influence of hypertension and other hemodynamic factors in atherogenesis. *Progress in Cardiovascular Diseases, XXVI* (3): 177, Nov/Dec, 1983. 5. Castelli WP: Remarks in the symposium, *Blood Pressure, Cholesterol and Coronary Heart Disease*, Washington, D.C., March 31, 1985. 6. Data on file, Wyeth Laboratories.

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WyTensin®
(guanabenz acetate)

Antihypertensive therapy that does not increase cholesterol

Brief Summary

Before prescribing, consult the complete package circular.

Indications and Usage: Treatment of hypertension, alone or in combination with a thiazide diuretic

Contraindication: Known sensitivity to the drug

Precautions: 1. Sedation Causes sedation or drowsiness in a large fraction of patients When used with centrally active depressants, e g , phenothiazines, barbiturates and benzodiazepines, consider potential for additive sedative effects 2. Patients with vascular insufficiency Like other antihypertensives use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease, or severe hepatic or renal failure 3. Rebound Sudden cessation of therapy with central alpha agonists like **Wytensin** may rarely result in "overshoot" hypertension and more commonly produces increase in serum catecholamines and subjective symptomatology

INFORMATION FOR PATIENTS Advise patients on **Wytensin** to exercise caution when operating dangerous machinery or motor vehicles until it is determined they do not become drowsy or dizzy Warn patients that tolerance for alcohol and other CNS depressants may be diminished Advise patients not to discontinue therapy abruptly

LAB TESTS In clinical trials, no clinically significant lab test abnormalities were identified during acute or chronic therapy Tests included CBC, urinalysis, electrolytes, SGOT, bilirubin, alkaline phosphatase, uric acid, BUN, creatinine, glucose, calcium, phosphorus, total protein, and Coombs' test During long term use there was small decrease in serum cholesterol and total triglycerides without change in high density lipoprotein fraction In rare instances occasional nonprogressive increase in liver enzymes was observed, but no clinical evidence of hepatic disease

DRUG INTERACTIONS **Wytensin** was not demonstrated to cause drug interactions when given with other drugs, e g., digitalis, diuretics, analgesics, anxiolytics, and antiinflammatory or antiinfective agents, in clinical trials However, potential for increased sedation when given concomitantly with CNS depressants should be noted

DRUG LAB TEST INTERACTIONS No lab test abnormalities were identified with **Wytensin** use

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY No evidence of carcinogenic potential emerged in rats during a two-year oral study with **Wytensin** at up to 9 5 mg/kg day, i e about 10 times maximum recommended human dose In the Salmonella microsome mutagenicity (Ames) test system, **Wytensin** at 200-500 mcg per plate or at 30-50 mcg/ml in suspension gave dose-related increases in number of mutants in one (TA 1537) of five *Salmonella typhimurium* strains with or without inclusion of rat liver microsomes No mutagenic activity was seen at doses up to those which inhibit growth in the eukaryotic microorganism, *Schizosaccharomyces pombe*, or in Chinese hamster ovary cells at doses up to those lethal to the cells in culture In another eukaryotic system, *Saccharomyces cerevisiae*, **Wytensin** produced no activity in an assay measuring induction of repairable DNA damage Reproductive studies showed a decreased pregnancy rate in rats given high oral doses (9 6 mg/kg), suggesting impairment of fertility Fertility of treated males (9 6 mg/kg) may also have been affected, as suggested by decreased pregnancy rate of mates, even though females received drug only during last third of pregnancy

PREGNANCY Pregnancy Category C WYTENSIN® MAY HAVE ADVERSE EFFECTS ON FETUS WHEN ADMINISTERED TO PREGNANT WOMEN A teratology study in mice indicated possible increase in skeletal abnormalities when **Wytensin** is given orally at doses 3 to 6 times maximum recommended human dose of 1 0 mg/kg These abnormalities, principally costal and vertebral, were not noted in similar studies in rats and rabbits However, increased fetal loss has been observed after oral **Wytensin** given to pregnant rats (14 mg/kg) and rabbits (20 mg/kg) Reproductive studies in rats have shown slightly decreased live-birth indices, decreased fetal survival rate, and decreased pup body weight at oral doses of 6 4 and 9 6 mg/kg There are no adequate, well-controlled studies in pregnant women **Wytensin** should be used during pregnancy only if potential benefit justifies potential risk to fetus

NURSING MOTHERS Because no information is available on **Wytensin** excretion in human milk, it should not be given to nursing mothers

PEDIATRIC USE Safety and effectiveness in children less than 12 years of age have not been demonstrated, use in this age group cannot be recommended.

Adverse Reactions: Incidence of adverse effects was ascertained from controlled clinical studies in U S and is based on data from 859 patients on **Wytensin** for up to 3 years There is some evidence that side effects are dose related Following table shows incidence of adverse effects in at least 5% of patients in study comparing **Wytensin** to placebo, at starting dose of 8 mg b i d

Adverse Effect	Placebo (%) n = 102	**Wytensin** (%) n = 109
Dry mouth	7	28
Drowsiness or sedation	12	39
Dizziness	7	17
Weakness	7	10
Headache	6	5

In other controlled clinical trials at starting dose of 16 mg/day in 476 patients, incidence of dry mouth was slightly higher (38%) and dizziness was slightly lower (12%), but incidence of most frequent adverse effects was similar to placebo-controlled trial Although these side effects were not serious, they led to discontinuation of treatment about 15% of the time In more recent studies using an initial dose of 8 mg/day in 274 patients, incidence of drowsiness or sedation was lower, about 20% Other adverse effects reported during clinical trials but not clearly distinguishable from placebo effects and occurring with frequency of 3% or less Cardiovascular—chest pain, edema, arrhythmias, palpitations Gastrointestinal—nausea, epigastric pain, diarrhea, vomiting, constipation, abdominal discomfort Central nervous system—anxiety, ataxia, depression, sleep disturbances ENT disorders—nasal congestion Eye disorders—blurring of vision Musculoskeletal—aches in extremities, muscle aches Respiratory—dyspnea Dermatologic—rash, pruritus Urogenital—urinary frequency disturbances of sexual function Other—gynecomastia taste disorders

Drug Abuse and Dependence: No dependence or abuse has been reported

Overdosage: Accidental ingestion caused hypotension, somnolence, lethargy, irritability, miosis, and bradycardia in two children aged one and three years Gastric lavage and pressor substances, fluids, and oral activated charcoal resulted in complete and uneventful recovery within 12 hours in both Since experience with accidental overdosage is limited, suggested treatment is mainly supportive while drug is being eliminated and until patient is no longer symptomatic Vital signs and fluid balance should be carefully monitored Adequate airway should be maintained and, if indicated, assisted respiration instituted No data are available on **Wytensin** dialyzability

Dosage and Administration: Individualize dosage A starting dose of 4 mg b i d is recommended, whether used alone or with a thiazide diuretic Dosage may be increased in increments of 4 to 8 mg/day every one to two weeks, depending on response Maximum dose studied has been 32 mg b i d , but doses this high are rarely needed

How Supplied: (guanabenz acetate) Tablets, 4 mg, bottles of 100 and 500; 8 mg and 16 mg, bottles of 100

Revised 2/14/85

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Ad Council

TWELVE IMPECCABLE EXCUSES FOR NOT GIVING BLOOD.

"1. I think I have lumbago.
2. I'm type Z negative.
3. I'm on the grapefruit diet.
4. I gave six months ago.
5. I just got back from Monaco.
6. The lines are thirteen blocks long.
7. My mother won't let me.
8. I didn't sign up.
9. I'm going out of town.
10. Asthma runs in my family.
11. I forgot to eat this morning.
12. I'm allergic to flowering magnolia."



Each one's a doozy, but we're hoping you won't use any of them. Give blood through the American Red Cross. Please, don't chicken out.

EXCUSES DON'T SAVE LIVES. BLOOD DOES.

American Red Cross

Mississippi State Medical Association Auxiliary

Convention 1986

Wednesday, June 4

12 noon	Registration/Hospitality
5:30 p.m.	MSMA President's Reception

Thursday, June 5

8:00 a.m.	Registration
9:00	Hospitality Center
9:00	MSMA House of Delegates
1:00 p.m.	Preconvention Board Meeting
3:00	Workshop — ''Flower Arranging''
6:00	Tulane, Tennessee Alumni
6:30	Millsaps Alumni
7:00	Ole Miss Alumni

Friday, June 6

8:00 a.m.	Registration
9:00	Hospitality Center
9:00	General Session
12 noon	Luncheon- Self Defense Workshop
2:30 p.m.	Board Meeting
6:30	MSMA/MSMA Auxiliary Reception/Banquet Silent Auction

Saturday, June 7

8:30 a.m.	Past President's Breakfast
10:00	Workshop — ''Financial Planning''

Sunday, June 8

8:00 a.m.	Church Services
9:00	MSMA House of Delegates







Construction Progress

Scaffolding, steel pilings, and construction equipment obscure the MSMA headquarters office from the street. The new four-story building is expected to be completed early in 1987. At press time, staff was preparing to move to temporary headquarters at 236 East Capitol Street.



First Birth for UMC *In vitro* Fertilization Program

The state's first "test tube" baby was born March 18. The parents of the baby — a healthy, full term girl — do not want their identity revealed.

The birth is the first for the *in vitro* fertilization program at the University of Mississippi Medical Center in Jackson. Currently two other women in the program are pregnant with births expected in early June and late September. The program started in 1983.

The procedural steps for the once-controversial method of conception include retrieving eggs from the mother, fertilizing them with the father's sperm in a laboratory dish, incubating the embryo in the laboratory for several days, then placing the developing embryo back in the mother's womb to grow and develop as any other fetus would.

Dr. Bryan Cowan, director of the UMC program, said the method is usually reserved for couples who have no other recourse in their attempts at pregnancy.

"The procedure is expensive because insurance and other third party payers don't cover the cost. And most couples try for several times before pregnancy results," Cowan said. The parents of the child born Tuesday, however, had gone through the procedure only once.

"We think our success rate is excellent," Cowan said, "and expect it to improve the longer we're in operation."

UMC Announces Faculty Appointments

Two have been named in School of Medicine faculty appointments at the University of Mississippi Medical Center for the current academic session.

Dr. Norman C. Nelson, vice chancellor for health affairs and medical school dean, announced the appointments following approval by the Board of Trustees of State Institutions of Higher Learning.

Appointed instructors in medicine (research) were Dr. Takashi Matsuoka and Dr. Wang Yu-zhi.

Dr. Matsuoka earned the M.D. in 1979 at Okayama University Medical School and completed residencies at Okayama Red Cross Hospital in 1980, and in 1981 at Kochi Rehabilitation Hospital in Japan. In 1983, Dr. Matsuoka was a trainee in hematology and allergology at Okayama University Medical School and has been a physician on staff at Okayama Prevention Society Hospital at Okayama, Japan.

Dr. Yu-zhi, who holds the Ph.D. from Beijing Medical College in China, was a researcher there from 1966-1967. He has been a research associate at the Institute of Radiation Medicine in Beijing, China, since 1967.

Services Held in Collins For Dr. C. P. Crenshaw, Jr.

Funeral services for Dr. Charles Posey Crenshaw of Collins were held March 15. Dr. Crenshaw passed away March 12 at his residence after an extended illness.

Dr. Crenshaw was a past president of the Mississippi State Medical Association, past president and charter member of the Mississippi Academy of General Practice, and a member of the American Medical Association and Southern Medical Association. He was a driving force behind the establishment of the Covington County Hospital in 1951.

Dr. Crenshaw was also a pharmacist, a member and deacon of Collins Baptist Church, a 32nd degree Mason, and a Shriner.

A veteran of World War II, Dr. Crenshaw served with the United States Navy Medical Corps. He was past state surgeon of the Veterans of Foreign War for Mississippi and a member of the American Legion. In 1947 he served as mayor of Collins.

He is survived by his wife, Mrs. Robertha Beard Crenshaw of Collins; a son, Charles Jyntre Crenshaw of Collins; two daughters, Mrs. L. P. (Ann) Duvall of Stuart, Florida, and Mrs. Karen Crenshaw McCraw of Milan, Tennessee; his mother, Mrs. Ruth Wolf Crenshaw of Collins; a sister, Mrs. Dola Mae Burton of Mobile, Alabama; and four grandchildren.

NEW ADDRESS
EFFECTIVE APRIL 28

MSMA headquarters has moved to 236 East Capitol Street. The association offices will occupy the third floor of the Great Southern National Bank building.

Ole Miss Medical Alumni Appoint Four to Board

Four have been named to the University of Mississippi Medical Alumni Chapter Board of Directors.

Dr. James C. Waites of Laurel, chapter president announced the appointments of Dr. Bryan Barksdale and Dr. Charles E. Farmer, Jr. of Jackson, Dr. Elmo P. Gabbert of Meadville and Dr. Keith Lay of Bay Springs. Each has been appointed for a three-year term on the board, followed by three years as an associate board member.

Dr. Barksdale received the B.S. in 1968 from Ole Miss and earned the M.D. degree in 1972 at the University of Mississippi Medical Center. He completed his internship at Duke University, then returned to UMC for his residency, where he was chief resident in internal medicine from 1976-1977. He was in private practice at the Medical Clinic of Jackson from 1976-1985, when he was named a fellow in cardiology at UMC.

Among Dr. Barksdale's professional memberships are the American Medical Association, Mississippi State Medical Association, Jackson Academy of Medicine and the American College of Cardiology. He is a member and past president of the Board of Directors of the Mississippi Arthritis Foundation, past president of the Mississippi Heart Association; and a member of the YMCA Board of Directors as director of Cardiac Rehabilitation, Board of Directors of the Mississippi Cancer Society, and the Governor's Council on Physical Fitness. Dr. Barksdale is past president of the Hinds County Ole Miss Alumni Association and a member in the Chancellor's Trust, the Guardian Society and Ole Miss Associates. He also is chairman of the Medical Alumni Students Together Committee.

Dr. Gabbert, a 1956 graduate of Delta State University, earned his M.D. degree in 1961 at UMC. He completed his internship in 1962 at John Sealy Hospital in Galveston, Texas and has since been in private practice as a family physician in Meadville since 1970. He is a member of the American Medical Association, Mississippi State Association, South Central Medical Society, and the American and Mississippi Academies of Family Medicine, of which he is secretary-treasurer in Mississippi.

Dr. Gabbert is a diplomate of the American Board of Family Practice and a fellow of the American Academy of Family Practice. An active member of the Meadville United Methodist Church, he is chairman of the Administrative Board. He is president of the Franklin County Heart Association, member and past president of the Franklin County Lions Club and team physician for the Franklin County Lions. He also is a member of the University of Mississippi Alumni Association and the Guardian Society.

Dr. Lay attended the University of Mississippi from 1957-1959, and earned the M.D. degree in 1963 at the University Medical Center. He completed his internship at Mobile General Hospital in 1964, and established his family medicine practice in Bay Springs. He holds professional memberships in the American Medical Association, Mississippi State Medical Association, Southern Medical Association and the Mississippi Academy of Family Practice. He also is a diplomate of the American Academy of Family Practice, and a member of the Guardian Society of the University of Mississippi Alumni Association.

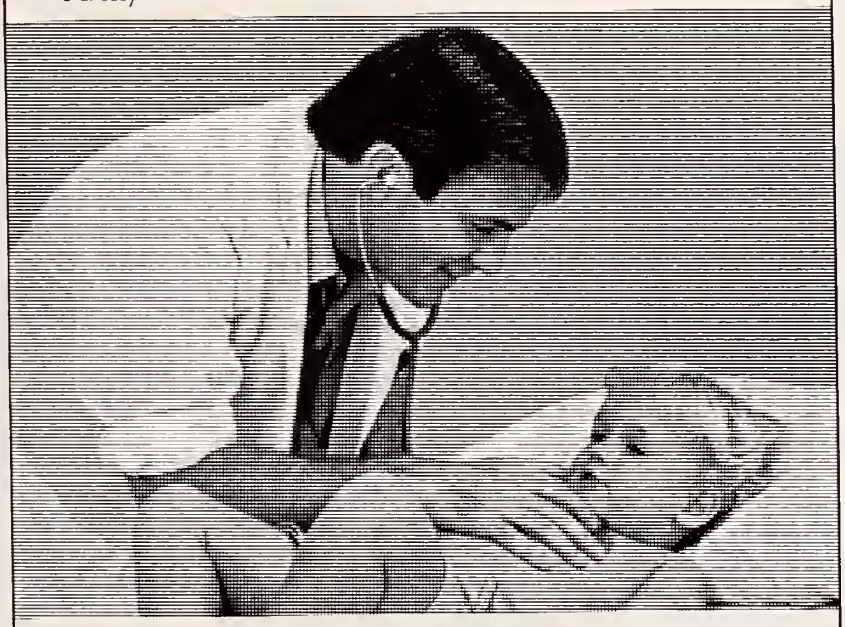
Dr. Farmer received the B.S. in 1956 from Mississippi College and earned his M.D. degree in 1959 at the Medical Center. From 1960-1964, he did his internship and residency in surgery at the University of Arkansas, and completed a residency in thoracic surgery in 1967 at the Marquette School of Medicine in Milwaukee, Wisconsin. Dr. Farmer served the U.S. Air Force from 1964-1966, and attained the rank of Captain. He is associated with the Mississippi Surgical Group in Jackson, and has been an attending surgeon for numerous institutions in the state. From 1983-1985, he was instructor in surgery at UMC, and also has served as chief of staff and member of the Board of Trustees at Hinds General Hospital. His professional memberships include the American Medical Association, Mississippi State Medical Association, Central Medical Society, Mississippi Thoracic Association, Southern Medical Association, Southeastern Surgical Congress, Society of American Gastrointestinal Endoscopic Surgeons, American Society of Bariatric Surgery, Society for Clinical Vascular Surgery, and the Jackson Surgical Society. He is a diplomate of the American College of Surgeons. A charter member of the Clinton YMCA and the Jackson Chamber of Commerce, he served from 1973-1977 as a member of the Clinton Board of Aldermen. He also is a member of the Guardian Society of the University of Mississippi Alumni Association.

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PERSONALS

GENE BARRETT of Jackson presented a paper at the American Academy of Orthopaedic Surgeons in New Orleans and also spoke at a sports medicine seminar in Vicksburg.

BLAIR BATSON of UMC attended a meeting of the government affairs council of the American Academy of Pediatrics in Washington, DC, and served as an examiner for the American Board of Pediatrics in Chapel Hill, North Carolina.

LAMAR BURROW of McComb has been appointed assistant state medical examiner for the southwest region of the state.

WALLACE CONERLY of UMC was guest speaker at a meeting of the pre-medical honorary society at Mississippi State University.

MARTIN DALTON of UMC was visiting professor and lecturer at Temple University's Abington Memorial Hospital in Philadelphia, Pennsylvania.

EMANUEL G. DEFRAITES of Ocean Springs has been elected chief of staff at CPC Sand Hill Hospital in Gulfport.

RICHARD J. FIELD, JR. of Centreville was guest speaker for the North Texas State Chapter of the American College of Surgeons in Dallas.

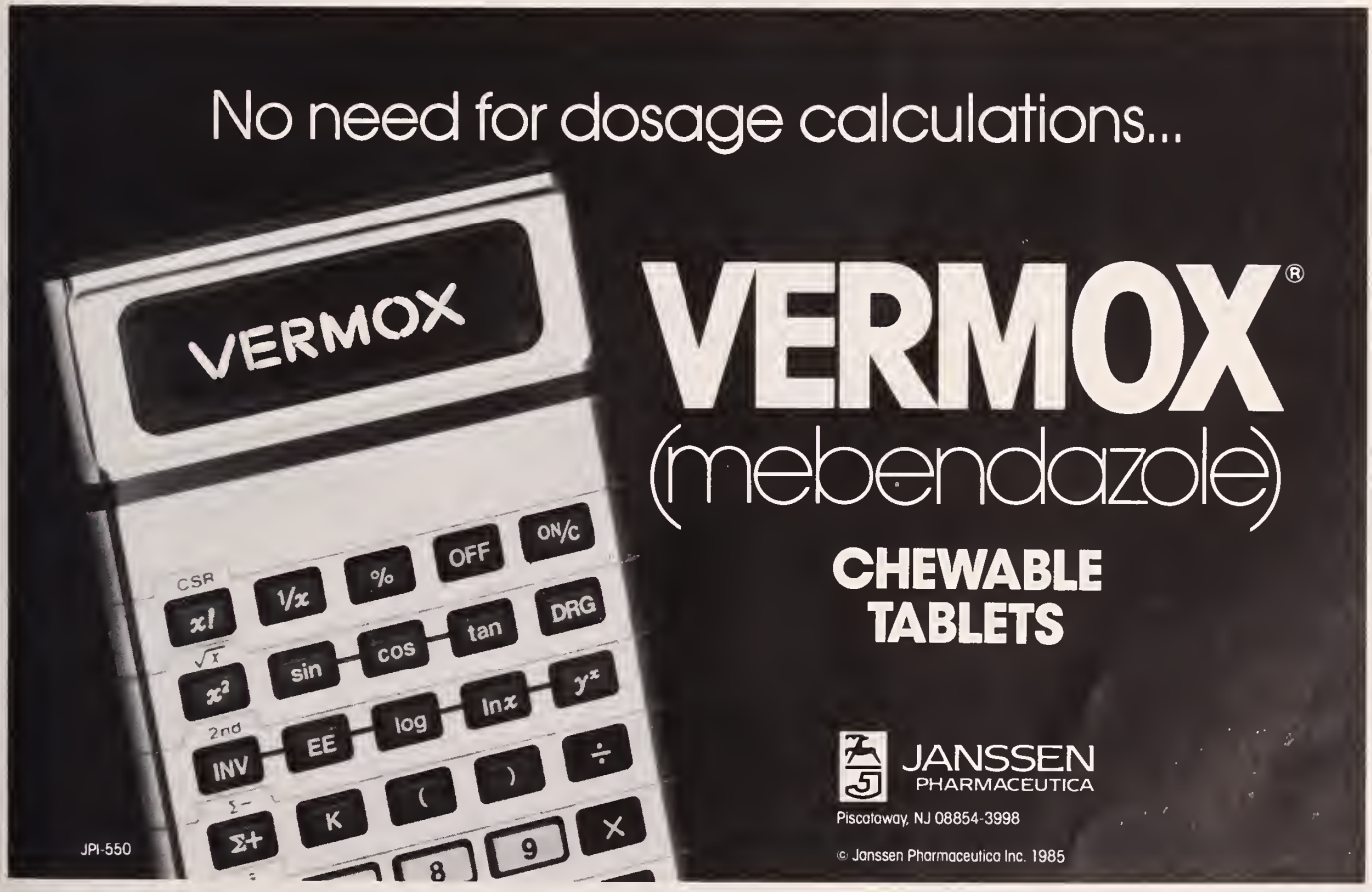
JOHN A. FRENZ announces the opening of his office for the practice of neurology and neurosurgery at 348 Crossgates Boulevard in Brandon.

LEE GIFFIN of Vicksburg was speaker at a sports medicine seminar sponsored by the Family Medicine Clinic of Vicksburg.

MARVIN V. HARVEY of McComb announces his retirement from the practice of general surgery.

JULIAN B. HILL, JR. of Tupelo became an institutional member of the Southwest Oncology Group at its meeting in San Antonio, Texas.

SHELBY HOWELL of Clarksdale was panel member for a seminar on domestic violence sponsored by the Clarksdale Junior Auxiliary and the local Mental Health Center.



PERSONALS / Continued

JIM K. HUDSON has associated with JOHN DRAKE and HAROLD HAWKINS of Ocean Springs for the practice of orthopaedic surgery.

MICHAEL E. JABALEY of Jackson recently was elected president of the American Society for Surgery of the Hand at its 41st annual meeting in New Orleans.

SAM JOHNSON of UMC recently was consultant to the Institute for Scientific Research in Boston.

JACK H. KAHLSTORF of Tupelo has been elected a fellow of the American Academy of Obstetrics and Gynecology.

HERBERT LANGFORD of UMC chaired a session of the American College of Cardiology 35th annual meeting in Atlanta.

JOHN W. MCFADDEN of Tupelo made a presentation to the medical staff of the North Panola County Hospital.

T. L. MOORE, JR. of McComb was the subject of a feature article and editorial tribute in the *Enterprise-Journal*, as he announced his retirement from the practice of family medicine.

WILLIAM NICHOLAS presented a paper at the Southern Sugar Club meeting in Hilton Head, South Carolina.

J. ELMER NIX of Jackson has been appointed to the advisory council for the Mississippi Workers' Compensation Commission.

STEVE PARVIN of Starkville has been recertified by the American Board of Surgery.

RANDOLPH J. ROSS of Hattiesburg has been appointed as clinical investigator for the Southeastern Cancer Study Group, urology division.

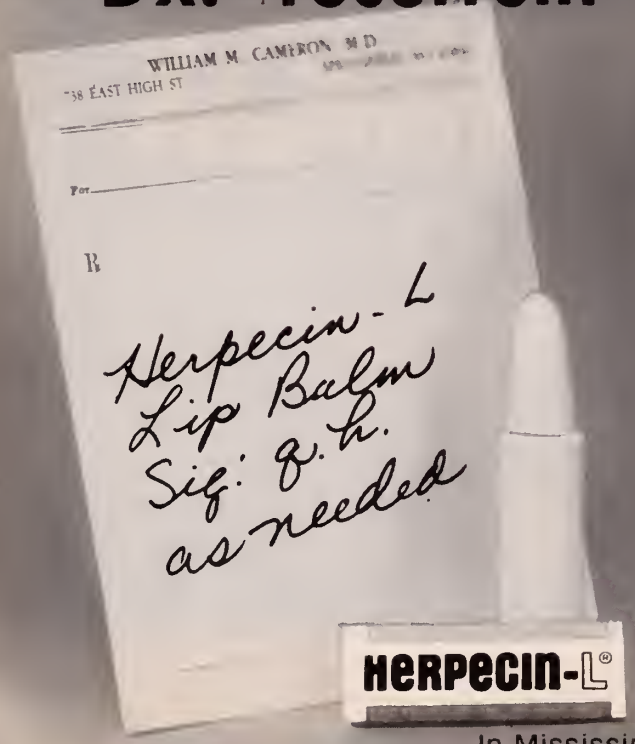
R. S. RUNNELS of Magee has been recertified by the American Academy of Family Physicians.

NATHAN SHAPPLEY of Hattiesburg has completed requirements for certification in lithotripsy.

DWIGHT H. SHORT of Gulfport has been elected to membership in the Society for Clinical Vascular Surgery.

RANDY VOYLES of Jackson spoke at the meeting of the Southeastern Surgical Congress in New Orleans in March.

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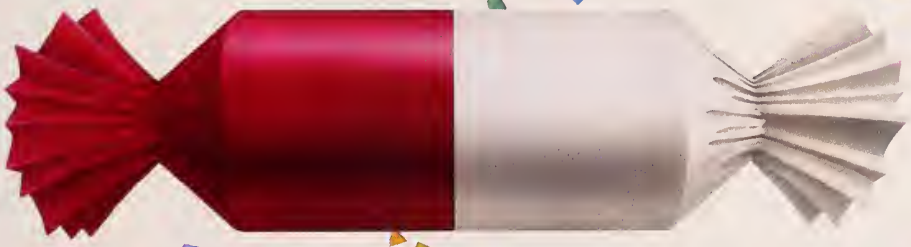
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Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.)* Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions*.) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C*: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported (See *Warnings*.) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984 2385

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NEW MEMBERS

BOSSCHER, DAVID B., Rolling Fork. Born Feb. 16, 1951; D.O., College of Osteopathic Medicine, Michigan State University, 1976; interned, one year, Oklahoma Osteopathic Hospital, Tulsa; family practice residency, Midland Hospital Center, East Lansing, MI, 1983-85 elected by West Mississippi Medical Society.

BRIHMADESAM, L. J., Jackson. Born India, Oct. 25, 1953; Jawaharlal Institute of Post Graduate Medicine, Pondicherry, India, 1976; interned Bay State Medical Center, Springfield, MA, one year; anesthesiology residency, same, one year; anesthesiology residency, University of Tennessee, Memphis, 1981-82; elected by Central Medical Society.

BRISTER, JAMES C., Hurley. Born Montgomery, AL, May 10, 1954; M.D., University of Mississippi School of Medicine, Jackson, 1981; interned, one year, UMC, Jackson; elected by Singing River Medical Society.

BRUNDAGE, STEPHANIE C., New Augusta. Born Washington, DC, Aug. 27, 1946; M.D., University of Miami School of Medicine, Miami, FL 1982; interned and family practice residency, University of Miami Affiliated Hospitals, Miami, 1982-85; elected by South Mississippi Medical Society.

COOK, HAROLD E., III, Jackson. Born Louisville, KY, May 30, 1954; M.D., University of Pittsburgh School of Medicine, Pittsburgh, PA, 1980; interned and medicine residency, Baltimore City Hospital, Baltimore, MD, 1980-83; anesthesiology residency, Johns Hopkins Hospital, Baltimore, 1983-85; elected by Central Medical Society.

DANIELSON, HARRY A., Biloxi. Born Puget Island, WA, Dec. 10, 1933; M.D., Loma Linda University School of Medicine, Loma Linda, CA, 1960; interned Los Angeles County General Hospital, Los Angeles, one year; general surgery, UCLA Program at Los Angeles County Harbor General Hospital, Torrance, CA, 1961-62; neurosurgery and neurology residency, White Memorial Medical Center, Downey, CA, 1962-66; elected by Coast Counties Medical Society.

DIXON, FREDERICK E. Keesler. Born Atlanta, GA, Jan. 8, 1953; M.D., University of Virginia School of Medicine, Charlottesville, 1979; interned Ochsner Foundation Hospital, New Orleans, one year; medicine residency and cardiovascular diseases fellowship, same, 1980-84; elected by Singing River Medical Society.

DUDDLESTON, DAVID N., Jackson. Born Jackson, MS, Oct. 29, 1956; M.D., University of Mississippi School of Medicine, Jackson, 1982; interned and medicine residency, University of Texas, Galveston, 1982-85; elected by Central Medical Society.

EARLEY, MICHAEL W., Ashland. Born Coldwater, OH, Oct. 10, 1954; M.D., Wright State University School of Medicine, Dayton, OH, 1982; interned and family practice residency, Cook County Hospital, Chicago, 1982-85; elected by North Mississippi Medical Society.

FISER, H. GREG., JR., Jackson. Born Clarksdale, MS, Oct. 28, 1954; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned and general surgery residency, University Medical Center, Jackson, 1980-85; elected by Central Medical Society.

FURR, MACK C., Jackson. Born Brookhaven, MS, May 22, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned and medicine residency, University Medical Center, Jackson, 1979-82; oncology fellowship, same, 1983-85; elected by Central Medical Society.

GANDOUR, MICHAEL J., Gulfport. Born Sistersville, WV, Nov. 10, 1954; M.D., University of Miami School of Medicine, Miami, 1980; interned and medicine residency, University of Alabama, Birmingham, 1980-82; pathology residency, same, 1982-85; elected by Coast Counties Medical Society.

GRIFFIN, T. DAVID, Vardaman. Born Baldwyn, MS, May 16, 1950; D.O., University of Health Sciences College of Osteopathic Medicine, Kansas City, MO, 1983; interned University Hospital, Kansas City, MO, one year; elected by Northeast Mississippi Medical Society.

HANKINS, RANDALL R., Hazlehurst. Born Raleigh, MS, Aug. 5, 1956; M.D., University of Mississippi School of Medicine, Jackson, 1982; interned and family practice residency, Druid City Hospital, Tuscaloosa, AL, 1982-85; elected by South Central Medical Society.

HENLEY, FELIX T., West Point. Born Clay County, MS, Feb. 10, 1921; M.D., University of Alabama School of Medicine, Birmingham, 1954; interned and radiology residency, Baptist Hospital, Birmingham, 1954-58; fellowship in diagnostic ra-

diology, University of Lund, Lund, Sweden, 1967; elected by Prairie Medical Society.

IRELAND, ROBERT B., JR. Clinton. Born Hattiesburg, MS, Oct. 7, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1981; interned and family practice residency, Druid City Hospital, Tuscaloosa, AL, 1981-84; elected by Central Medical Society.

LEWIS, ROBERT L., Woodville. Born Centreville, MS, Sept. 5, 1956; M.D., University of Mississippi School of Medicine, Jackson, 1981; interned and medicine residency, University Medical Center, Jackson, 1981-84; elected by Amite Wilkerson Counties Medical Society.

LOBRANO, CHARLES M., Long Beach. Born Monroe, LA, Jan. 26, 1954; M.D., Louisiana State University School of Medicine, New Orleans, 1979; interned University of Tennessee, Memphis, one year; anesthesiology residency, Tulane University, New Orleans, 1983-85; elected by Coast Counties Medical Society.

MARTIN, NANCY S., Jackson. Born Yazoo City, MS, Sept. 14, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1983; interned and radiology residency, University Medical Center, Jackson, 1983-85; elected by Central Medical Society.

NEILL, JOHN C., Jackson. Born Jackson, MS, Dec. 28, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned, one year, University of Arkansas, Little Rock; surgery residency, Louisiana State University, New Orleans, 1979-80; neurosurgery residency, University Medical Center, Jackson, 1980-85; elected by Central Medical Society.

PREAU, WM. J., III, Pascagoula. Born New Orleans, Oct. 25, 1956; M.D., Louisiana State University College of Medicine, New Orleans, 1982; interned and anesthesiology residency, Ochsner Foundation Hospital, New Orleans, 1982-85; elected by Singing River Medical Society.

SIMO, J. BENJAMIN, McComb. Born El Salvador, March 10, 1938; M.D., University of El Salvador, 1964; interned Hahnneman Medical College, Philadelphia, PA, 1969-70; urology residency, same, 1970-71; urology residency, Ochsner Medical Foundation, New Orleans, 1973-77; elected by South Central Medical Society.

SMITH, BARBARA H., Greenwood. Born Jackson, MS, July 30, 1944; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned University Hospital, Jackson, one year; anesthesiology residency, Tulane Medical Center, New Orleans, 1982-84; elected by Delta Medical Society.

SMITH, GLENN N., Hattiesburg. Born Memphis, Dec. 16, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned, medicine residency and hematology-oncology fellowships, University Medical Center, Jackson, 1978-85; elected by South Mississippi Medical Society.

SY, BERTRAND O., Bay St. Louis. Born Philippines, Jan. 14, 1946; M.D., Cebu Institute of Medicine, Cebu City, Philippines, 1970; interned and pediatric residency, St. John's Episcopal Hospital, Brooklyn, NY, 1974-78; elected by Coast County Medical Society.

WALKER, ROBERT LEE, Hazlehurst. Born Jackson, MS, Dec. 1, 1956; M.D., University of Mississippi School of Medicine, Jackson, 1982; interned and family practice residency, University of Alabama, Tuscaloosa, 1982-85; elected by South Central Medical Society.

YELVERTON, RICHARD L., JR., Jackson. Born Jackson, MS, June 9, 1958; M.D., University of Mississippi School of Medicine, Jackson, 1984; interned University Medical Center, Jackson, one year; elected by Central Medical Society.

— Next Month in JOURNAL MSMA —

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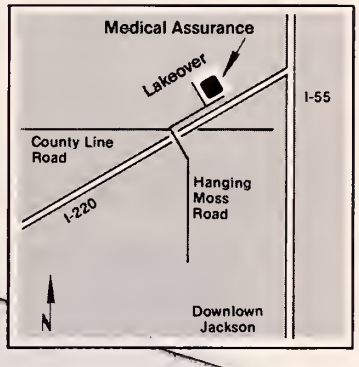
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POSTGRADUATE CALENDAR

June 13
CLINICAL UPDATE: MANAGEMENT OF PSYCHIATRIC AND SLEEP DISTURBANCES IN THE PRIMARY CARE PATIENT
University Medical Center, Jackson

June 19-20
STROKE UPDATE
EIGHTH ANNUAL NEUROLOGY SYMPOSIUM
Sheraton Regency, Jackson

For additional information, contact the Division of Continuing Medical Education, University Medical Center, 984-1300.

THE PRESIDENT SPEAKING

(Continued from page 126)

and not just sit back and be run over.

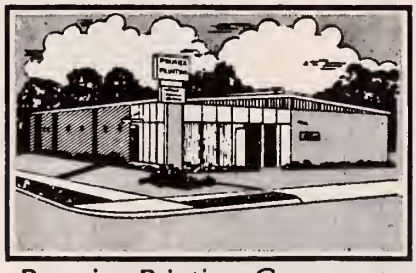
A lot has been going on this past year at the state and national level. I have been to many meetings where I have seen and heard leaders of today and tomorrow. I am pleased to report to you that organized medicine is in good hands, and the future is bright. Today, I would not hesitate to recommend and encourage medicine to the next generation.

The practice of medicine has always been a challenge. Our patients are better informed than ever before and this has contributed to their expectation of good, if not perfect, results. Economic pressures and loss of control to third-party payors have forced us into decisions and actions we had not dreamed of a few years ago. The decision to form a statewide HMO-IPA and the tremendous response of the physicians across the state is a giant step forward to help insure our ability to control our practices and better serve our patients.

This past year as your president, I have had the opportunity of a lifetime. I can't begin to tell you the deep satisfaction it has given me to travel from one component society to another and get to meet and visit physicians "at home." I want to take this opportunity to thank all members of MSMA for allowing me to be your spokesman and honoring me as your president. I want to thank you for the many courtesies you have shown Billie and me. As we end one year and begin another, I hope you will join with me and enthusiastically look not backward, but forward to the future.

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MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 15-19, 1986, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

State and Local

Mississippi State Medical Association, 118th Annual Session, June 4-8, 1986, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, June 25-28, 1986, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, February, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, January, May, and November. H. S. Barrett, Secy., P.O. Box 1810, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington, Yazoo.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, Secy., Mail: Ms. Jenkins, P.O. Box 4053, Meridian 39305. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, Meetings scheduled quarterly. Fred G. Emrich, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, January. Charles S. Watras, 612 Summit St., Winona 38967. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, September, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. William Billington, Secy., 731 Medical Center Dr., West Point, MS 39773. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 1st Wednesday, February, April, June, August, October, December. John J. McCloskey, Secy., 3003 Short Cut Rd., Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. George R. Bush, Secy., 307 S. 13th Ave., Laurel 39440. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly
Mississippi State Medical Association
735 Riverside Drive
Jackson, MS 39216

Mississippi Chapter
American College of Surgeons
Box 5229
Jackson, MS 39216

North Mississippi Medical Center
830 Gloster Avenue
Tupelo, MS 38801

North Panola County Hospital
Drawer 160
Sardis, MS 38666

Forrest General Hospital
Box 1897
Hattiesburg, MS 39401

Singing River Hospital
P.O. Box 112
Pascagoula, MS 39567

Mississippi Baptist Hospital
1225 N. State Street
Jackson, MS 39201

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Alcorn Drive
Corinth, MS 38834

Gulf Coast Community Hospital
4642 W. Beach Boulevard
Biloxi, MS 39531

Greenwood Leflore Hospital
1508 Leflore Avenue
Greenwood, MS 38930

Jefferson Davis Memorial Hospital
Box 1488
Natchez, MS 39120

Gulfport Memorial Hospital
4500 13th Street
Gulfport, MS 39501

King's Daughter Hospital
Box 948
Brookhaven, MS 39601

Oxford-Lafayette County Hospital
P.O. Box 946
Oxford, MS 38655

Riverside Hospital
Lakeland Drive
Jackson, MS 39208

Biloxi Regional Medical Center
1559 Lafayette St.
Biloxi, MS 39533

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Meridian, MS 39301

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The Mississippi Disability Determination Services now has a program available for medical society meetings and hospital staff meetings. The purpose of this program is to explain the Social Security Disability program, the medical documentation requirements, and how the disability determination process works. Any group interested in this presentation should also contact the Medical Relations Office.

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Index to Advertisers

Ayerst Laboratories **10A, 10B, 10C, 10D**

Campbell Laboratories 142
Canton Exchange Bank 146
Curtis 1000 Information Systems **10**

Disability Determination Services 148

Harreld Chevrolet 125

Janssen Pharmaceutical 141

Knoll Pharmaceutical 142B, 142C, 142D

Eli Lilly and Company **4**

Miss. Baptist Medical Center..... **8**
Medical Assurance Co. of Miss. 145

MSMA Benefit Plan ..... **second cover**

Premier Printing 146

Roche Laboratories ..... **third, fourth covers**

Smith Kline and French 142A

Trans Union Credit Information Co. 140

University of Alabama **6, 7**
The Upjohn Company 134A
U.S. Army **12**
U.S. Army Reserve 139

Jon Wimbish **14**
Wyeth Laboratories **134B, 134C, 134D**

Thomas Yates & Co. **16**



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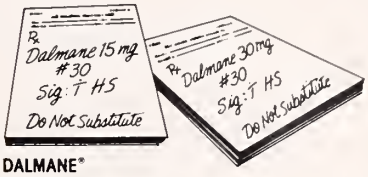
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References: **1.** Kales J, *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A, *et al. Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A, *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A, *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Dement WC, *et al: Behav Med*, pp. 25-31, Oct 1978. **7.** Kales A, Kales JD: *J Clin Psychopharmacol 3*:140-150, Apr 1983. **8.** Tennant FS, *et al:* Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984. **9.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977.

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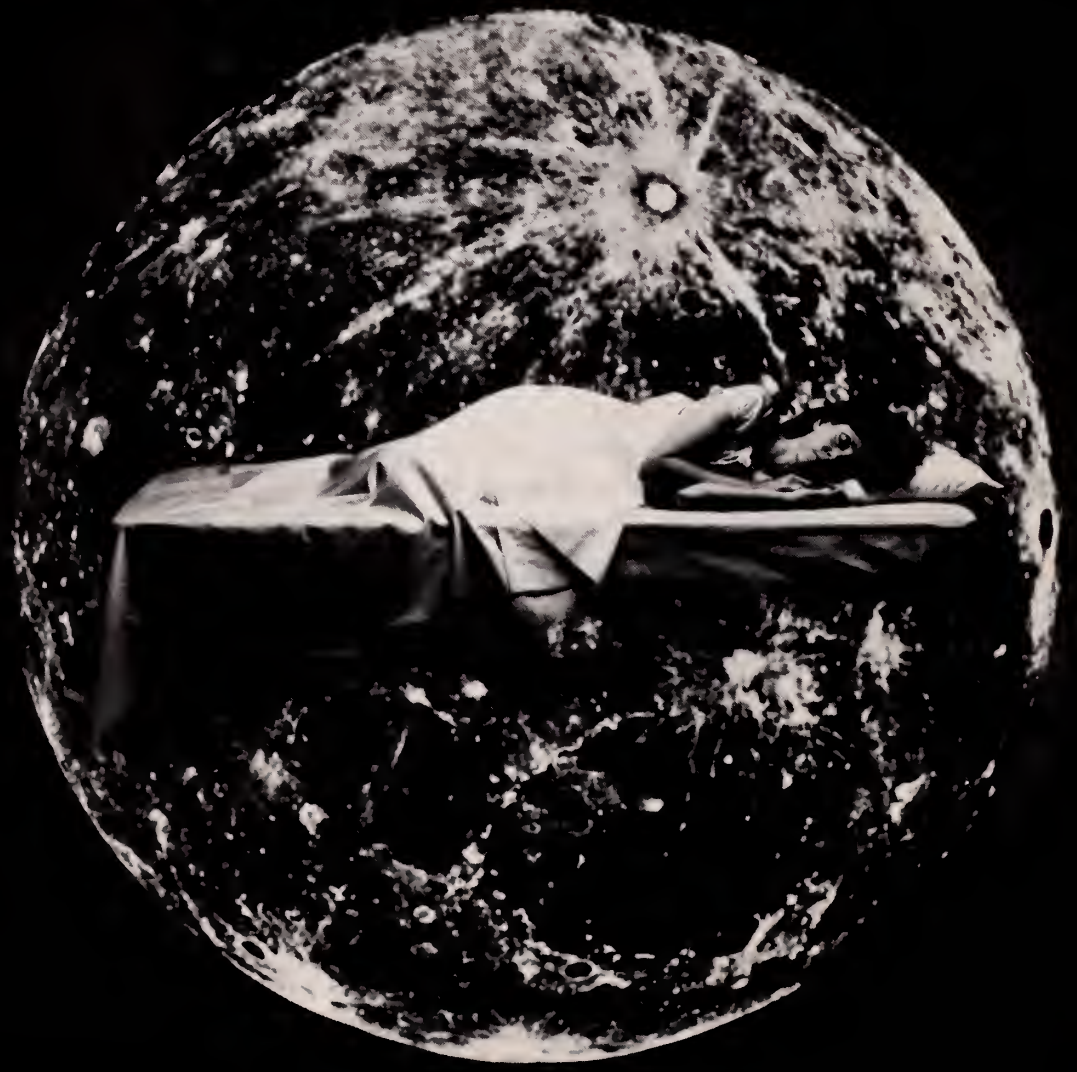
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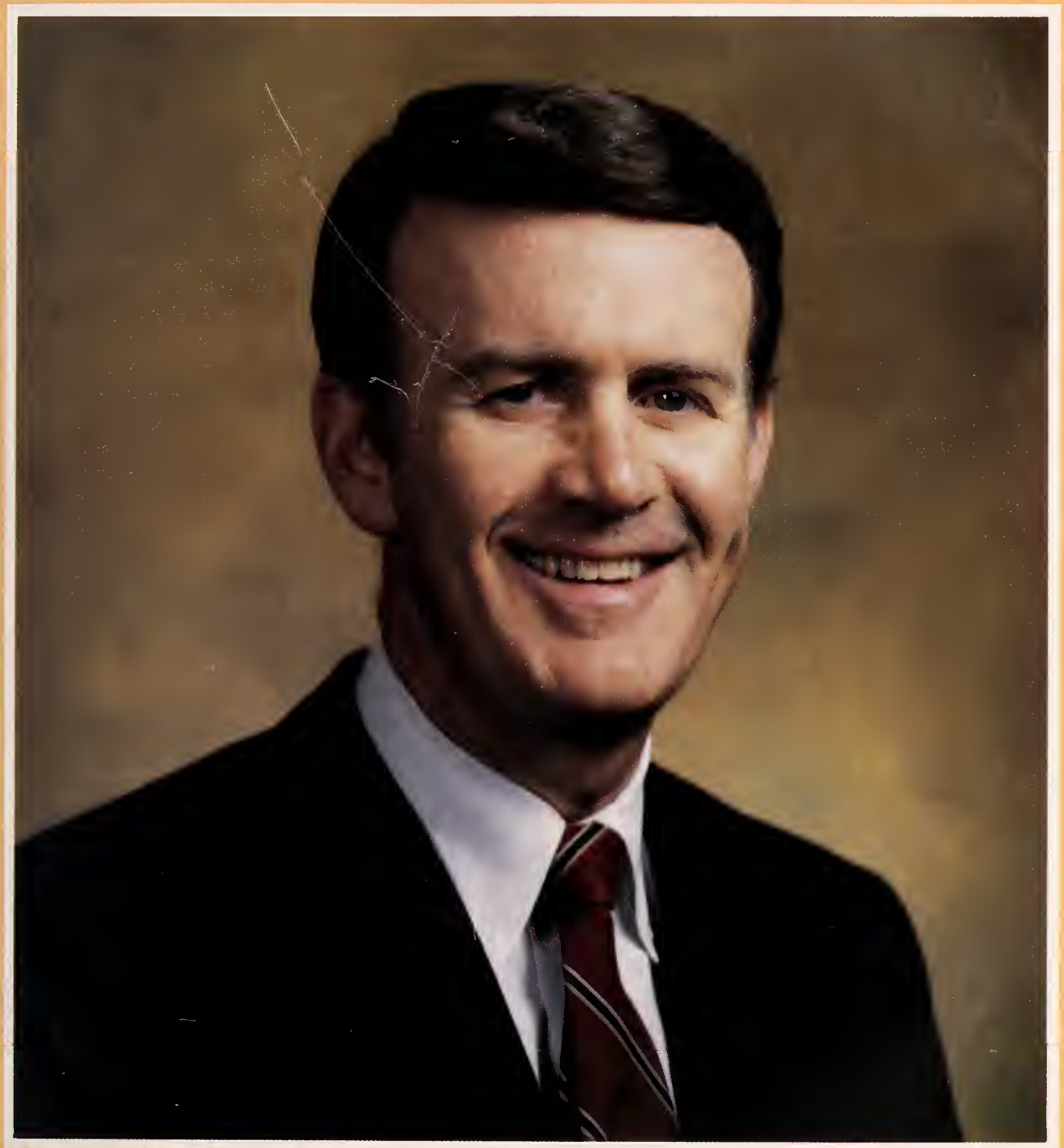


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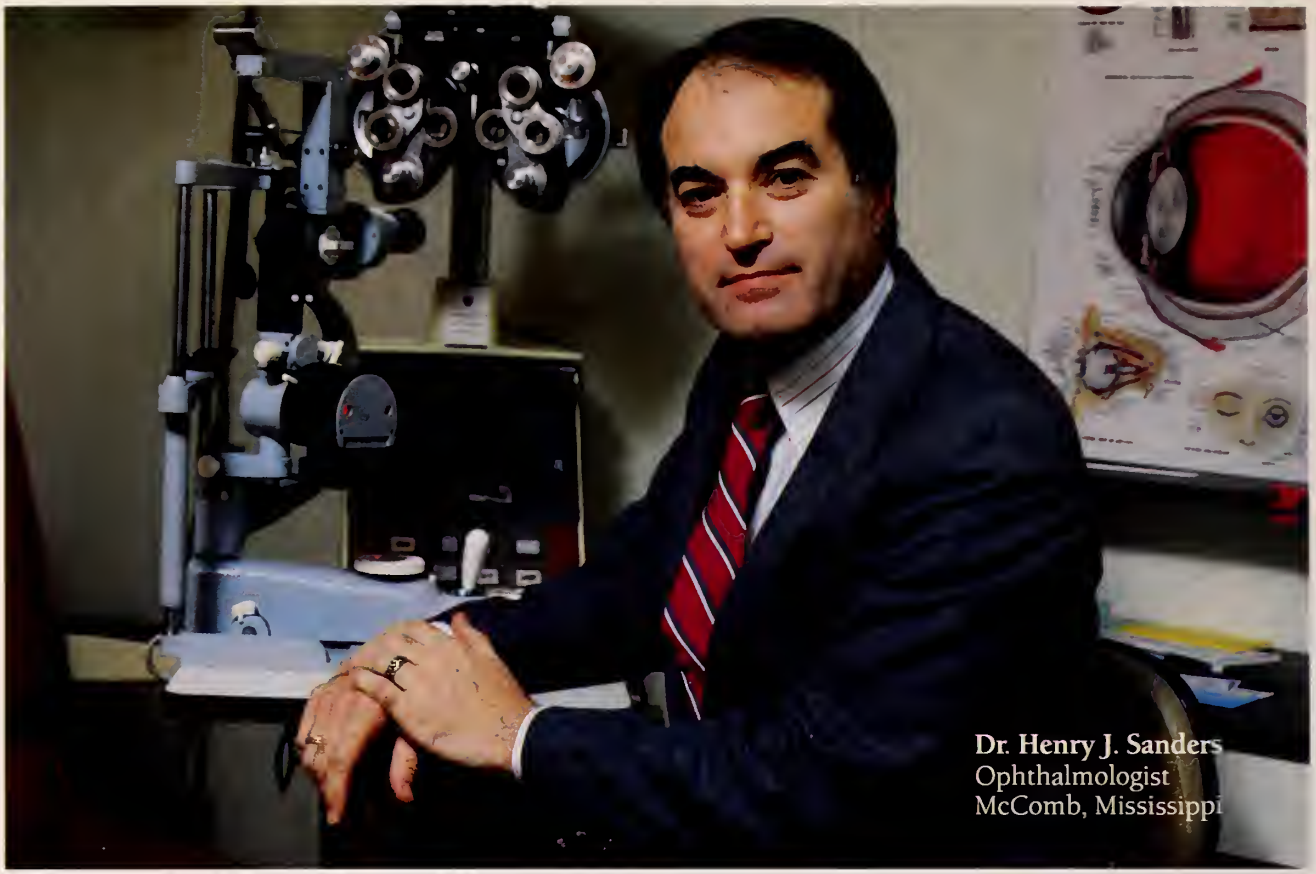
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June 1986

JOURNAL of the MISSISSIPPI State Medical Association



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JUNE 1986, VOLUME XXVII, NUMBER 6

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The Journal of the Mississippi State Medical Association is owned and published monthly by the Mississippi State Medical Association, founded 1856, at P.O. Box 5229, Jackson, Mississippi 39216. Subscription rate, $25.00 per annum; $35.00 per annum for foreign subscriptions; $2.25 per copy, as available. Advertising rates furnished on request. Printed by The Ovid Bell Press, Inc., Fulton, Missouri. Second-class postage paid at Jackson, Mississippi, and at additional mailing offices. POSTMASTER: Send address changes to Mississippi State Medical Association, P.O. Box 5229, Jackson, Mississippi 39216.

CONTENTS

ORIGINAL PAPERS

Early Diagnosis and Management of Bleeding Meckel's Diverticula **149** Billy W. Long, M.D.

Carotid Body Tumors **155** W. Wilson Defore, M.D.

SPECIAL ARTICLE

Mississippi Physician Participation in Medicaid **159** Marcia Weaver, M.S., Ed.S., Robert B. Weaver, Ph.D., R.P.T., Robert L. Abney, M.D. and David G. Watson, M.D.

EDITORIAL

Where Did We Go Wrong? **165** Arthur A. Derrick, M.D.

THIS MONTH

What Can We Do For MSMA? **164** The President Speaking
165 Letters
166 Comment
169 Medical Organization
172 New Members
173 Deaths
175 Personals
177 Medico-Legal Brief

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NEWSLETTER

June 1986

Dear Doctor:

After conducting interviews with various management consultant firms, the MSMA HMO/IPA Boards last month retained Physicians Health Plan of Ohio (PHP) to begin the initial phase of operations.

In a letter to HMO/IPA members describing the action, the presidents of the Boards noted PHP's "proven track record in HMO/IPA development and management" and its "strong record of physician control and direction." David R. Steckler, M.D. of Natchez is president of Mississippi Physicians Health Insurance Co. (HMO) and Robert Allen Smith, M.D. of Jackson is president of Mississippi Physicians Practice Association (IPA).

PHP has been in operation since 1980 and currently has 100,000 subscribers and more than 3,200 participating physicians. The organization, founded by the local medical society, is based in Columbus, which recently replaced Cleveland as Ohio's most heavily populated area. There are nearly 20 HMOs active in Columbus, which has 11 hospitals and 2,100 physicians. PHP has 55% of the market share.

First tasks by PHP staff are to design marketing and benefit plans and to conduct a survey of provider costs and physicians' fees. The HMO/IPA Boards will review PHP's work and recommendations at the end of the initial operations phase, in about 120 days.

Three insurance companies -- John Hancock, Hartford and Northwestern National Life -- have entered into a joint venture to establish PPOs and HMOs with the intent of developing a national network in 50 locations across the country. The three are considering adding two more partners, with a $100 million investment to be shared equally. A data analysis service and utilization review may also be offered.

Sincerely,

Patsy Silver

Patsy Silver
Managing Editor



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Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 5D% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Dbserve regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

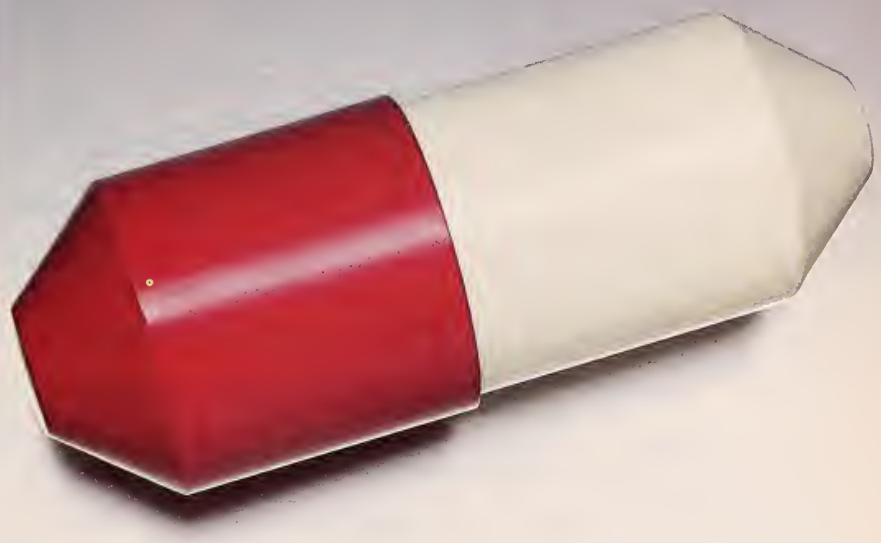
Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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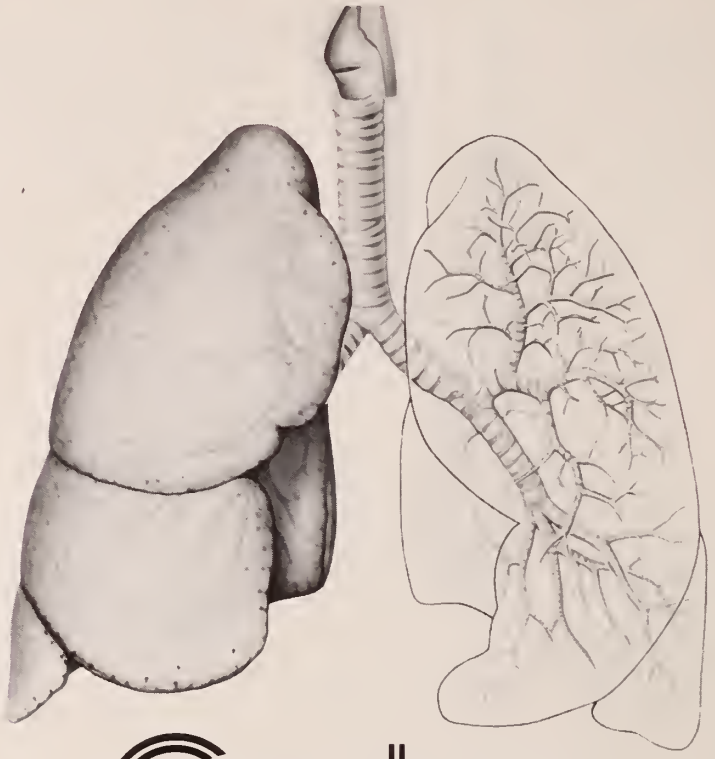
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250-mg Pulvules® t.i.d. offers effectiveness against the major causes of bacterial bronchitis

Haemophilus influenzae, H influenzae, Streptococcus pneumoniae, Streptococcus pyogenes
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Note: Ceclor® is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Ceclor® (cefaclor)

Summary. Consult the package literature for prescribing information.

Indications: Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae, Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Contraindications: Known allergy to cephalosporins.

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- In renal impairment, safe dosage of Ceclor may be lower than that usually recommended. Ceclor should be administered with caution in such patients.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, erythema multiforme, serum-sickness-like reactions): 1.5%; usually subside within a few days after cessation of therapy. These reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children)
- Abnormal urinalysis; elevations in BUN or serum creatinine
- Positive direct Coombs' test
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly)

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DATELINE

Physician Fee Schedule Recommended for Medicare

Washington, DC - Congressional Budget Office (CBO) has recommended paying physicians by a fee schedule as the most feasible way to reform Medicare reimbursement. A CBO study concluded that the action could save $1.2 billion over the next five years, if based on average payment allowances under today's system. The study also favors controls on the volume of physician services and prefers regional fee schedules over national fee schedules.

More High School Students Using Cocaine

Washington, DC - Cocaine use among American high school students appears to be at a record level, according to a National Institute on Drug Abuse survey. Seventeen percent of seniors in the class of 1985 said they have tried the drug, with 6.7% having used it within 30 days of the survey. About 80% of the seniors acknowledged harmful effects of using cocaine regularly, but only about 34% saw much risk in experimenting with it.

U.S. Increases Battle Against Health Fraud

Washington, DC - The U.S. government has stepped up the battle against health care fraud, which brings its perpetrators anywhere from $500,000 to $25 million each year. An aggressive program involving the FDA, the FTC, and the Postal Service will emphasize the need for coalitions of public, private, state and local agencies to combat the flow of misinformation about benefits of unproved medical devices, drugs, and regimens.

AIDS a Leading Cause Of Death in New York

New York, NY - AIDS is the leading cause of death for New York City men aged 30 to 39 years, and the second leading cause of death for women aged 30 to 34, according to a report in the May 2 JAMA. Since recognition of the syndrome in 1981, more than 4,400 cases have been reported in NYC. Incidence continues to increase each year, with 64% more cases in the first six months of 1985 than in the same period of 1984.

MRI Detects Tumors Effectively

Chicago, IL - Magnetic resonance imaging accurately identified the organ of origin of tumor masses and differentiated soft tissues from fat, fluid or hemorrhage in a study of 134 children reported in the May Archives of Surgery. MRI was better than computed tomography in defining size and extent of soft-tissue tumor masses, and accurately defined spread of bone sarcoma in bone marrow and invasions of abdominal blood vessels by Wilms' tumors.



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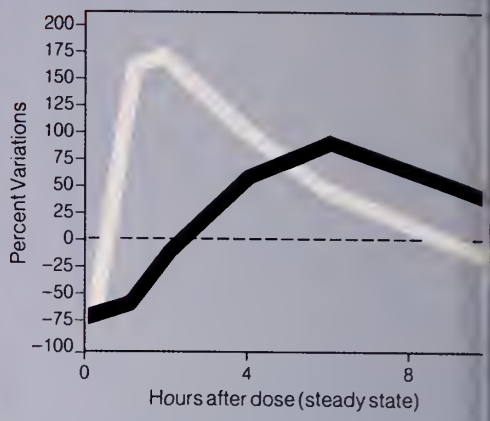
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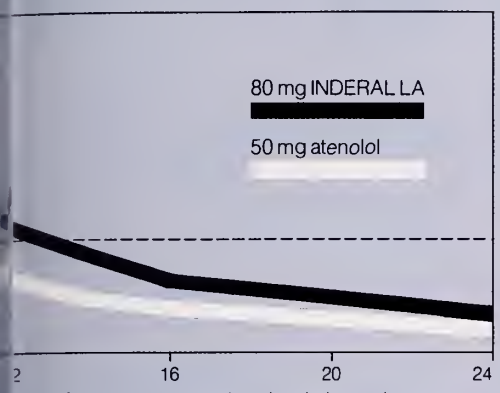
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As with all fixed-combination antihypertensives, INDERIDE LA is not indicated for the initial treatment of hypertension.

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Once-daily INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



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BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULARS.)*

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INDERIDE®LA Brand of PROPRANOLOL HYDROCHLORIDE (INDERAL® LA) and HYDROCHLOROTHIAZIDE **(Long Acting Capsules)**
INDERAL LA AND INDERIDE LA Capsules should not be considered simple mg-for-mg substitutes for INDERAL and INDERIDE Tablets. Please see package circulars

CONTRAINDICATIONS

Propranolol hydrochloride (INDERAL® LA): Propranolol is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol.

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS

Propranolol hydrochloride (INDERAL® LA): CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated, and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or propranolol should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction following *abrupt* discontinuance of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution, since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS

Propranolol hydrochloride (INDERAL® LA): GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. Propranolol is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that propranolol may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs, such as reserpine should be closely observed if propranolol is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies, in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose. There are no adequate and well-controlled studies in pregnant women. Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: Propranolol is excreted in human milk. Caution should be exercised when propranolol is administered to a nursing mother.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

Hydrochlorothiazide: GENERAL: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely: Hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs irrespective of cause are: Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect of digitalis (eg, increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content.

Any chloride deficit is generally mild and usually does not require specific treatment, except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism, such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

DRUG INTERACTIONS: Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

PREGNANCY: Pregnancy Category C. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnancy requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

NURSING MOTHERS: Thiazides appear in human milk. If use of the drug is deemed essential, the patient should stop nursing.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL® LA): Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure, intensification of AV block, hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss; emotional lability; slightly clouded sensorium; and decreased performance on neuropsychometrics.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation; mesenteric arterial thrombosis; ischemic colitis.

Allergic: Pharyngitis and agranulocytosis; erythematous rash; fever combined with aching and sore throat; laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis; nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia. LE-like reactions, psoriasiform rashes; dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have *not* been associated with propranolol.

Hydrochlorothiazide:

Gastrointestinal: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation; jaundice (intrahepatic cholestatic jaundice); pancreatitis; sialadenitis.

Central Nervous System: Dizziness, vertigo; paresthesias; headache; xanthopsia.

Hematologic: Leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

Cardiovascular: Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity: Purpura, photosensitivity, rash; urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis); fever, respiratory distress, including pneumonitis, anaphylactic reactions.

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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
June 1986, XXVII, Number 6

ORIGINAL PAPERS

Early Diagnosis and Management of Bleeding Meckel's Diverticula

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Between December 1981 and May 1985, the author has participated in the evaluation and treatment of four patients with acutely bleeding Meckel's diverticula. The medical literature up until now has emphasized the difficulty clinicians often encounter in making a prompt and accurate diagnosis of a bleeding Meckel's diverticulum. In all four of the patients evaluated, a bleeding Meckel's diverticulum was believed to be the most likely diagnosis at the time of surgery. The diagnosis was reached in less than 24 hours in three of the four patients. The author presents brief case reports, discusses Meckel's diverticula, and describes his approach.

Case Report 1

A 29-YEAR-OLD WOMAN developed the abrupt onset of bright red rectal bleeding on the evening prior to her hospital admission. She had four more bloody bowel movements during the day of admission to the hospital. Her hematocrit at the time of her admission was 39%. Blood pressure and pulse were 120/80 and 80 respectively. However, within a few hours after her admission, she became hypotensive; and a repeat hematocrit was 25%. She was transfused with four units of packed red cells. The following morning upper endoscopy was done to look for peptic ulcer disease, and the examination was normal. Then, colonoscopy was attempted. The colon was examined to the splenic flexure, and no lesions were apparent. Fresh blood was seen coming from above the examined area. A bleeding scan using 20 mCi of technetium demonstrated an abnormal area, after only 10 minutes scanning, in the right lower abdomen just to the right of L3,4 (see Figure 1). A bleeding Meckel's diverticulum was suspected. Later, less than 24 hours after her admission, she was taken to the operating suite where a Meckel's diverticulum was resected. The gross appearance showed gastric and small bowel mucosa, with an obvious ulcer at the junction of these tissues. Histologically, both gastric and pancreatic tissues were identified. The patient was discharged on the seventh postoperative day.

Case Report 2

A 24-year-old woman gave a three to four day history of severe lower abdominal cramping pain. She next noted feeling weak and tired. On the night of admission she developed the sudden onset of profuse bright red rectal bleeding with passage of maroon clots. She came to the emergency room for evaluation. Nasogastric tube aspirate was negative

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for blood. Initial hematocrit was 32%, but fell to 27% after intravenous hydration. Physical examination was unremarkable. Upper endoscopy was done and was normal. A fiberoptic proctoscopy examination was successful to 60 cm. The mucosa was normal, and fresh blood was coming from above that level. A technetium bleeding scan suggested a Meckel's diverticulum. A small bowel series showed dilated loops of distal small bowel (see Figure 2). A small bowel diverticulum and narrowing of the terminal ileum beyond the diverticulum were demonstrated (see Figure 3). At surgery, a Meckel's diverticulum was found with an ulcer in the distal ileum which had scarred and produced partial small bowel obstruction. This segment of bowel was resected, and the patient had a uneventful recovery. Approximately 72 hours elapsed between the time of her admission and her surgery.

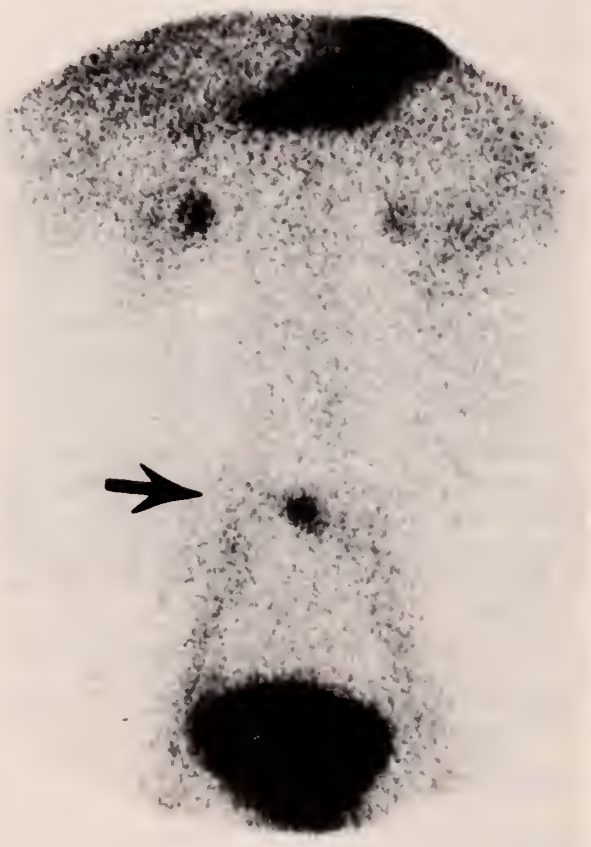


Figure 1. A technetium scan from Case 1. An abnormal focus of activity (arrow) is seen in the lower abdomen. At the top of the figure, radioactivity is seen in the stomach and kidneys, and at the bottom activity has accumulated in the bladder.

Case Report 3

A 7-year-old boy described a two to three day history of cramping periumbilical pain of moderate severity. On the night of admission to the hospital, he developed the sudden onset of nausea and vomiting on two separate occasions. This was shortly followed by passage of blood per rectum. Initial hematocrit was 33.5%. He appeared pale and had mild periumbilical tenderness. A bleeding scan done on the night of admission was negative. However, a repeat scan done the following morning showed an abnormal collectioin of isotope in the right lower abdomen (see Figure 4). A Meckel's diverticulum was suspected. He was taken to the operating suite, and under general anesthesia, both upper endoscopy and colonoscopy were done. Both examinations were normal, except for blood coming from above the ileocecal valve. A laporotomy followed immediately (less than 16 hours after admission), and a large Meckel's diverticulum was found with a hemorrhagic ulcer. Ectopic gastric mucosa was seen histologically. He had an uneventful postoperative course.



Figure 2. A radiograph from Case 2 showing a small bowel series. An ileal diverticulum with air contrast (arrow) and slightly dilated loops of small bowel proximal to the diverticulum can be seen.



Figure 3. A spot radiograph close-up of the ileal diverticulum filled with barium from Case 2.



Figure 4. A technetium scan from Case 3 showing an abnormal area of radioactivity in the right lower abdomen. Liver and spleen activity are apparent at the top of the figure, and the abdominal aorta and iliac vessels are outlined by the radiolabeled red blood cells.

Case Report 4

A 17-year-old man gave a history of feeling weak and tiring easily for several days. Two days prior to admission, he first noted passage of dark maroon blood mixed with bright red blood in the stool. The bleeding continued, and the patient suffered a syncopal episode and was brought to the emergency room. Initial hematocrit was 22%. He was transfused with four units of packed red blood cells. Upper gastrointestinal radiographs and a barium enema were normal. Subsequently, an upper endoscopy and fiberoptic proctoscopy were done. The only notable finding was maroon stool coming from above the level of colon examined. A technetium scan showed an abnormal area of activity in the right lower abdomen. He was then taken to the operating suite, less than 20 hours after admission, where a Meckel's diverticulum was found with active bleeding seen at the time. A resection was carried out, and he had an uneventful postoperative course. Both gastric and pancreatic tissue were present in the resected specimen (see Figure 5).

Discussion

Meckel's diverticulum was first described by Johann Meckel in 1809. This is the most frequently encountered diverticulum of the small intestine and the most common congenital anomaly of the intestinal tract. Meckel's diverticulum is found on the antimesenteric border of the ileum about two feet, and rarely more than three feet, from the ileocecal valve. The diverticulum represents persistence of the intraabdominal portion of the omphalomesenteric duct. The diverticulum is usually one to two inches long and has a wide-mouthed base. It is found in two percent of the population, affecting men twice as often as women.[1,2] It may contain two types of ectopic tissue, gastric and pancreatic. Approximately one-third of the patients develop symptoms in the first year of life, over 60% occur before age ten, and 80% of symptomatic patients are under age

fifteen. Many of the diverticula are found incidentally at surgery or autopsy. One recent large series found that 17% of Meckel's diverticula actually caused symptoms.[2] Based on current estimates, up to 100,000 Americans over age 15 will develop complications from a Meckel's diverticulum.[3, 4]

Obstruction, bleeding, and diverticulitis are the three most common complications of Meckel's diverticulum. The most common problem in adults is intestinal obstruction, but inflammation is the more common presentation in children. Obstruction may result from volvulus or kinking around a band running from the tip of the diverticulum to umbilicus, abdominal wall, or mesentery. Obstruction may also occur by intussusception with the diverticulum acting as the intussusceptum. Rarely, the diverticulum becomes incarcerated in an indirect inguinal hernia (Littre's hernia).[2]

Another major complication is acute inflammatory reactions in the diverticulum. Meckel's diverticulitis is clinically indistinguishable from appendicitis. The incidence of perforation and peritonitis is approximately 50%. Also, if the vitelline duct persists intact, maintaining a patent communication between the ileum and umbilicus, an omphalomesenteric fistula may develop.



Figure 5. A photomicrograph from Case 4 showing both gastric (top) and pancreatic (bottom) tissues from the resected Meckel's diverticulum.

Bleeding is also a common manifestation and occurs as a more frequent complication in males. One-third of patients present with anemia, melena, or massive painless bleeding. This is due to peptic ulceration produced by secretion of acid-pepsin from ectopic gastric mucosa within the diverticulum. Rarely, peptic ulceration may result in obstruction comparable to gastric outlet obstruction from chronic peptic ulcer disease.

The nuclear bleeding scan may be helpful in localizing the site of the bleeding to the diverticulum.[5, 6, 7] The physiologic secretion of ^{99m}technetium pertechnetate by gastric mucosa provides the basis for this method. Since 57% of Meckel's diverticula contain gastric mucosa, the ^{99m}technetium pertechnetate scan is often helpful in localizing this anomaly. Usually, an intravenous dose of 30 to 100 μCi per kilogram body weight is administered to the patient. Then, serial images are obtained at ten-minute intervals for 60 minutes. Finding the isotope concentrated in the right lower quadrant of the abdomen is considered a positive test. The sensitivity of the scan may be improved pharmacologically through different mechanisms with the use of pentagastrin, cimetidine, or glucagon.[6, 7] Also, lateral, upright, and postvoiding views may provide additional technical information.

In the general evaluation and treatment of patients with acute and massive gastrointestinal hemorrhage, the first priority is hemodynamic stabilization. Once the patient has been given intravenous fluid and/or blood, and is stable, the evaluation turns to identifying the cause and anatomic site of the bleeding. The physician hopes that the bleeding will cease spontaneously, but he must try to localize the bleeding site should the patient need urgent surgery.

There are several logical steps to be followed in finding the likely site of bleeding.[8, 9, 10] First, passing a nasogastric tube and aspirating gastric contents are helpful. If blood or bile is aspirated, this is useful information; upper gastrointestinal bleeding is confirmed if blood is aspirated, and is unlikely if clear bile is returned. However, if neither bile nor blood can be aspirated, upper gastrointestinal bleeding is still possible; and we follow the recommendation of others and proceed with upper panendoscopy.[9] Gastric and duodenal ulcers, esophageal varices, and Mallory-Weiss tears are common and need to be looked for in all patients with massive bleeding.

TABLE I

CLINICAL FEATURES OF FOUR PATIENTS WITH BLEEDING MECKEL'S DIVERTICULA

Patient/Age/Sex	*Time Between Admission and Surgery* (HOURS)	*Units of Blood Transfused*	*Lowest Hgb Prior to Surgery*	*Histology of Resected Diverticulum*
J.P./29 y.o./F	23	4	9.4	gastric & pancreatic
J.M./24 y.o./F	72	2	9.7	gastric
B.S./7 y.o./M	16	1	10.9	gastric
J.T./17 y.o./M	20	9	6.4	gastric & pancreatic

Therapeutic endoscopy with newer devices such as the heater probe can often control bleeding from peptic ulcers.[10]

Should the upper gastrointestinal tract studies prove negative, then the next most likely bleeding site is the large intestine. Colonic diverticula, angiodysplasias, polyps, tumors, and colonic varices may cause massive lower intestinal bleeding at times. Our next test is usually a nuclear bleeding scan in an effort to localize the site to upper or lower, right or left abdominal quadrants. Diverticuli and angiodysplasias are common causes for bleeding in older adults, but not in children and young adults. Thus, the scan must be interpreted with the patient's age and the more likely diagnostic possibilities in mind. In older patients, abdominal angiography is often useful to define the exact site of bleeding if the bleeding scan is positive. However, in younger patients, a positive nuclear scan in the right lower abdomen is virtually diagnostic of a Meckel's diverticulum.[5]

The "bleeding scan" differs from the Meckel's scan in one major way. In the bleeding scan the patient's own red blood cells are labeled with ^{99m}technetium pertechnetate in vitro and the cells are reinjected into the patient. The bleeding scan is positive only when active bleeding is occurring. The labeled blood leaks from the bleeding site into the gut, causing pooling of the isotope and a hot-spot on scan. The Meckel's scan uses less radioactivity, and the ^{99m}technetium is given in the free form. A positive Meckel's scan relies on the uptake of the free ^{99m}technetium by ectopic gastric mucosa.

Flexible sigmoidoscopy or full length colonoscopy can often be accomplished in patients suspected to have lower gastrointestinal bleeding, but several hours are needed to cleanse the colon adequately using an electrolyte purge.[9] In younger individuals, it is extremely important to diagnose acute ulcerative colitis, since this often responds to nonsurgical measures. Likewise, bleeding angiodysplasias and diverticula in the colon may be treated through the colonoscope with the heater probe or laser,[10] thus avoiding surgery in an elderly or unstable patient.

By following these guidelines the physician will be able to localize the bleeding site, or be reasonably certain of the site in most patients. The patient's age and the diagnoses which have been excluded on the basis of the above mentioned tests help the physician to form his opinion. Finding a Meckel's diverticulum is especially rewarding, since the surgery is relatively simple, and these younger patients are cured for life.

In summary, Meckel's diverticulum should be considered when patients develop mechanical obstruction of the distal ileum, lower small bowel bleeding, or signs of inflammation or peritonitis in the mid or lower abdomen. Several newer diagnostic methods allow clinicians to make an earlier and more accurate diagnosis when this entity is suspected. ★★★

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Acknowledgements

The author gratefully acknowledges the physicians who also participated in the care of these patients: Frank R. Briggs, M.D., Thais E. Brown, M.D., Richard H. Johnson, M.D., Anthony B. Petro, M.D., Robert R. Rester, M.D., E. L. Whitfield, M.D., and Richard L. Yelverton, M.D.

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Carotid Body Tumors

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Tumors of the carotid body are infrequently encountered. The presenting symptom is usually a painless mass in the neck. The diagnosis is best confirmed by arteriography. Surgical excision is recommended at the time of diagnosis for all good risk patients to avoid later technical difficulties encountered with further growth and vascularity of the tumor. With refined diagnostic techniques and operative adjuncts, these lesions can be resected with minimal morbidity, the author notes.

TUMORS OF THE CAROTID BODY are usually lesions originating from the nonchromaffin paraganglia of the carotid bifurcation in the tissue considered to be chemoreceptors. The paraganglia system is formed by numerous collections of neuroepithelial cells dispersed throughout the body. Those associated with the ortho-sympathetic system are characteristically nonchromaffin tissue, and are concentrated in the head, neck and mediastinal area. Tumors arising from these structures are best designated as paragangliomas and carotid body tumors are subclassified as chemodectomas. Neoplasms of the carotid body arise at the bifurcation of the common carotid artery and become closely adherent to it. They are very vascular in nature. These tumors are best demonstrated by arteriography. Ultrasound and technetium 99 scanning are useful diagnostic adjuncts. However, the clinical diagnosis may not be made until its characteristic location is determined at the time of surgical exploration. Surgical excision of these tumors is recommended in the good risk patient at the time of diagnosis to obviate later technical difficulties with continued growth and vascularity.

Case Report

J. S., a 60-year-old white female, presented with a mass in the right neck. She had experienced previous seizure-like activity, and on physical examination a bruit was heard over the right carotid artery. A Doppler scan was performed which showed a tumor-like mass at the carotid bifurcation (see Figure 1). Because of the suspicion of a carotid body tumor, a carotid arteriogram was performed, and it revealed a characteristically vascular tumor with splaying of the internal and external carotid arteries (see Figure 2). At surgical exploration, a reddish-brown, firm vascular mass, with a thin fibrous capsule fusing with the adventitia at the carotid bifurcation, was identified and excised by subadventitial dissection (see Figure 3). Blood loss was minimal during the procedure. Pathological examination revealed this to be a carotid body tumor (see Figure 4) with characteristic chief-cell nests surrounded by numerous capillaries. The patient's postoperative course was uncomplicated and there were no neurologic deficits.

Discussion

The first description of the carotid body was by Von Haller in 1743, and a tumor of the carotid body was first reported by Marchard in 1891. In 1903, Scudder reported the first case in the English literature of the successful resection of a carotid body tumor.[1]

The carotid body is a reddish-brown structure, approximately 5 mm in size, located within the adventitial layer of the posterior aspect of the common carotid bifurcation. The carotid body contains the largest collection of chemoreceptor tissue in the body. Tumors of the carotid body are very unusual, and belong to the group of tumors classified as chemodectomas. These tumors are nonchromaffin paraganglioma originating from paraganglionic tissue, most likely of neural crest origin. The cells normally function as chemoreceptors which are responsive to bodily alterations in pO_2, pCO_2, and pH of the blood.

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Similar types of cells are located in the glomus jugulare, the middle ear, the ganglion nodosum, the aortic arch, and other areas.[2]

Carotid body tumors are the most common chemodectomas encountered clinically, and a possible relationship to the Multiple Endocrine Neoplasm Syndrome has been proposed. Carotid body tumors are slow-growing neoplasms which may increase in size at varying rates with a multiplicity of resultant symptoms and disability. The majority are benign in nature, but a few are malignant as evidenced by local recurrence and spread to contiguous structures, as well as lymphatic and hematogenous metastasis to the regional nodes, lung, bone and heart. The tumors are characteristically unilateral, but may appear bilaterally, especially in a familial pattern. Pleomorphism with frequent mitotic figures is a feature of malignancy. However, there is generally poor correlation between the histologic findings and the tumor behavior.[3]

The presenting symptom is usually a painless mass at the bifurcation of the common carotid artery. The mass may have gradually increased in size and is usually mobile side to side, but not superiorly or inferiorly. Symptoms result from pressure on the vagus, hypoglossal, glossopharyngeal and sympathetic nerves. Symptoms include pain in the neck

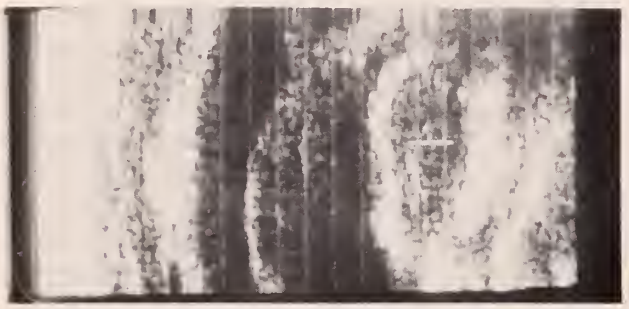


Figure 1. Doppler scan showing carotid body tumor.



Figure 2. Carotid arteriogram showing carotid body tumor.



Figure 3. Carotid body tumor at the time of surgical excision.



Figure 4. Carotid body tumor following surgical removal.

or ear, dysphasia, hoarseness, syncope, dizziness, tinnitis, visual blurring.

Differential diagnosis of this entity includes carotid aneurysm, branchiogenic cyst, neurofibroma, and metastatic tumor. Dynamic radionuclide angiograms utilizing technetium 99 pertechnetate is a useful screening test in these patients prior to anteriography. The most important diagnostic adjunct, however, is arteriography. Carotid body tumors characteristically show lateral displacement of the carotid artery, separation of the internal and external branches, and striking vascularity. Arteriography is helpful in planning the operative approach and yields important information regarding the patency of the carotid vessels and the adequacy of the cerebral circulation.[4]

The definitive treatment of carotid body tumors is surgical excision. Shamblin has proposed a surgical classification of tumors of the carotid body as follows:

Type I: Small and easily separated from the carotid vessel wall.
Type II: Partially surrounding the carotid artery and requiring careful subadventitial dissection to prevent arterial injury.
Type III: Large and completely surrounding and adhering to the carotid bifurcation.

The major problem in treatment has been the intimate relation of the tumor to the carotid artery, and the possible serious complications with hemorrhage and cranial nerve deficits.[5] Innovations in operative techniques, including shunts and grafts, have markedly improved the morbidity statistics. One of the most important advances has been the subadventitial removal of the tumor from the carotid vessels, since the media is almost never involved. Direct biopsy of the mass in this area is to be avoided because of the risk of pseudoaneurysm or hematoma formation. At present, surgical removal is advocated for small tumors, for symptomatic lesions, for aggressively growing and suspected malignant tumors, and in good risk patients under the age of 50. For the elderly patient with a small, asymptomatic lesion, observation is generally recommended. Radiation therapy may occasionally be of value for the non-resectable type lesion.

Carotid body tumors are intimately adherent to the carotid bifurcation, and surgical extirpation is frequently difficult. The tumors are often extremely vascular, and hemorrhage may become a major problem. Larger chemodectomas with an upward growth may be particularly hazardous. With current diagnostic modalities, low risk anesthesia, autotransfusion, and refined vascular techniques, few patients are not surgical candidates.[6, 7] The surgical rationale is predicated on the assumption that some of these tumors are invasive, even though they appear histologically benign. There is continuing controversy regarding the natural history and potential for malignant changes in these tumors.

Conclusion

A cautious approach to the surgical management of tumors of the carotid body is warranted, predicated on their location and vascular nature. The most important aspect of the surgical management of carotid body tumors is the accurate preoperative diagnosis by carotid arteriography. Routine excision of the tumor is recommended in the good risk patient at the initial time of diagnosis to avoid the difficulty of subsequent excision of an enlarging and highly-vascular tumor with possible encasement of the carotid artery. This approach, along with improved diagnostic and surgical techniques, should result in minimal morbidity and mortality in these patients.

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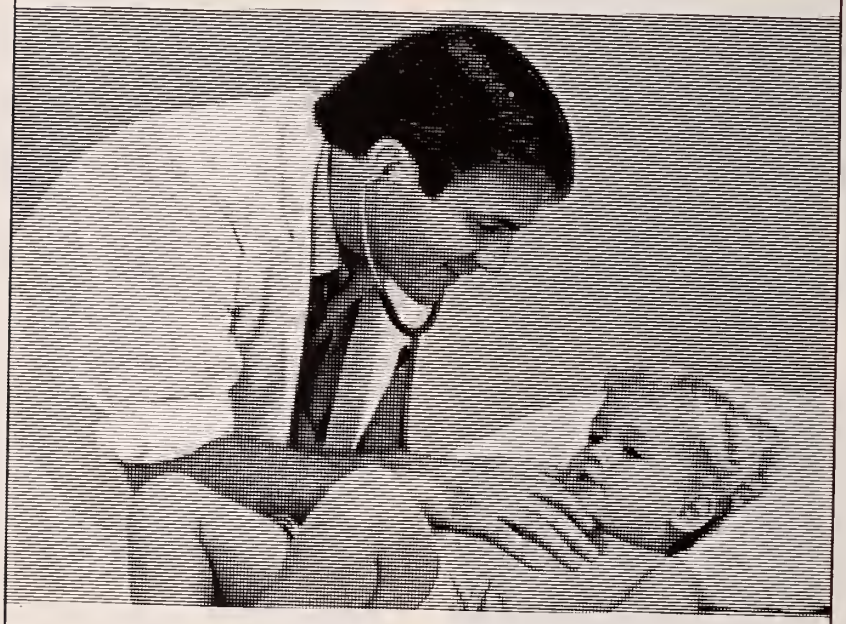
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Mississippi Physician Participation in Medicaid

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MEDICAID WAS established by Congress in 1965 under Title XIX of the Social Security Act. Its primary purpose was to provide medical services for the poor. The intended method for providing these services was through the use of the office-based physician. Based on both cost effectiveness and quality of care the office-based physician was designated as the key to providing the medical needs of the poor.

The Medicaid program has grown tremendously over the years. Between 1969 and 1976 the number of states participating increased from 39 to 49. Mississippi joined the program in 1970. Beneficiaries expanded from 12 million to 23 million and total expenditures rose from $4 to $14 billion.[1] In 1983 total Medicaid expenditures were 10 percent of our national health bill, or approximately $35 billion. The funding is based on a federal-state match ranging from 50 to 78 percent. In 1983 Mississippi's rate was 77.36 percent. This means that for every Medicaid $1.00 spent for health care $.77 were federal funds.

Twenty percent of all the nation's children are eligible for Medicaid benefits. In Mississippi this figure is closer to 30 percent. In 1983 only 14.5 percent of all Medicaid dollars were spent on children.[2] Children's medical care needs utilize less of the Medicaid dollar than either elderly or disabled recipients. McManus reported that while children represented 50 percent of the total Medicaid recipients in 1980 nationally, they accounted for only 17.5 percent of the total Medicaid medical vendor payments.[3]

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As the Medicaid program expanded, a potentially negative trend surfaced. Physician participation seemed to be declining. If this trend intensified, the basic philosophy of serving the needy through the office-based physician would be threatened. Access to appropriate health care would decline and the poor would be forced to use more expensive hospital emergency departments.

Several studies were initiated to seek answers to problems involving physician participation in Medicaid. Davidson[4] found evidence of decreased physician participation. Forty percent of California physicians had decreased participation in Medicaid by 1974. In Michigan the rate of participation between 1973 and 1976 dropped 15 percent.

An American Academy of Pediatric (AAP) study[5] indicated physician participation was constant or decreased in all but two states between 1978 and 1983. Equally significant, the AAP study showed physicians were limiting participation with Medicaid patients. Between 1978 and 1983 limitation of participation increased from 26 percent to 35 percent. California exhibited an increase in limited participation from 22 to 51 percent, Georgia from 15 to 48 percent and Nebraska from six to 42 percent.

Davidson, et al[6] surveyed 793 pediatricians in 13 states. They studied variables influencing participation or non-participation and percent of practice in Medicaid for pediatricians not at capacity. Variables were grouped as situational variables, ie, physician, patient and geographic characteristics, and policy variables, ie, paperwork, reimbursement levels and time periods. The 13-state study reported that policy variables had a greater impact on physician participation than situational variables.

Reported in another study, Davidson[4] found the primary factors in decreased physician participation were low rates of reimbursement, delays in and unpredictability of payment, limits of coverage, ar-

bitrary and rigid definitions of services, short-term patient eligibility, and complicated and changing paperwork.

State policies were also a key to participation.[4, 6, 7] Physicians will participate if program policies are not too much trouble, fees are reasonable, patient eligibility is stable, and physicians are more free to exercise their professional judgement. In general, physicians in states which provide more services to Medicaid recipients and higher reimbursements participate more in Medicaid.

Davidson[4] made the following recommendations to increase physicians' participation in Medicaid: increase services to maximize the physician's ability to treat patients appropriately; patients should remain eligible until initial treatment is completed; newborns should be automatically eligible if the mother is eligible (current federal policy); and teenage prenatal care should be increased to reduce future costs.

All studies reviewed found that the effectiveness of the Medicaid program depended upon the participation of the office-based physician. Studies, however, indicated a trend toward decreased physician participation. A study of Medicaid physician participation was needed because Mississippi physician participation was unknown. Mississippi, one of the poorest states in the nation, needs maximum physician participation to provide health care to our low income and high health risk population.

Methodology

The Mississippi Chapter of the American Academy of Pediatrics surveyed Mississippi physicians to document the recent trends of physician participation in Medicaid. To determine reasons for physician's limited participation was the primary purpose of this study. The survey also obtained data on physician competition and workloads.

A self-administered questionnaire was designed with assistance from the AAP, and mailed to 1039 physicians licensed in Mississippi. Four physician groups were surveyed: pediatricians, obstetricians, general practice and family practice. A total of 582 questionnaires were returned (56%) and 541 questionnaires were analyzed (52%).

Physicians were asked to respond to questions concerning the extent of their Medicaid participation. They were also asked to respond as "Very Important, Somewhat Important" or "Not at All Important" to a series of questions concerning reasons for limiting Medicaid participation. A copy of the complete questionnaire is available through the Mississippi Chapter-AAP.

Discussion of Results

Approximately twice as many family practice physicians responded compared to the other physician groups. A further analysis indicated approximately 90 percent of all respondents worked in primary care practices. When asked about capacity, 42 percent of the physicians described their workload as being under capacity in their practices, whereas only five percent indicated they were over capacity. Questionnaire results indicated that during the previous year, approximately seven percent of the physicians surveyed did not accept Medicaid patients.

The current level for physicians accepting some or all Medicaid patients is 85 percent (see Table I). Almost half of the Mississippi physicians surveyed participated fully in Medicaid. That is, they accept all Medicaid patients who contact them for medical care. Thirty-five percent of the respondents indicated limited participation. That level of participation compares similarly with figures presented earlier in the review of literature.

Physicians were asked whether their practices had changed in 1984 with respect to numbers of Medicaid patients seen in the recent past. Slightly over 60 percent of the physicians indicated no change in Medicaid practice. More physicians indicated an increase in Medicaid participation (22%) than a decrease (14%) in 1984.

As indicated in the above findings Mississippi physicians are continuing to accept Medicaid patients. The general non-participatory rate seems to be six to seven percent of all physicians. With approximately 42 percent of the physicians surveyed indicating they are under capacity in their practices, the general climate for maintaining the high participation rate would seem favorable.

Table II ranks physicians' perceived competition. As expected, other physicians were listed as the primary source of competition. The second most indicated source was the health department. Community clinics, hospital outpatient services and midwives ranked third, fourth, and fifth respectively.

Table III shows physician reasons for limiting Medicaid participation. Physicians were asked to indicate whether limiting reasons were "Very Important," "Somewhat Important," or "Not Important." These responses were given values of 3, 2 and 1, respectively, in order to compute a Total Score for comparison of these limiting reasons.

Chi-square analysis indicated significant differences among the ten limiting reasons ($p = 0.0001$). In particular, low Medicaid payments ranked as the

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Contraindications: Severe left ventricular dysfunction (see *Warnings),* hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.)* Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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TABLE I

PERCENT PHYSICIANS CURRENTLY PARTICIPATING IN MEDICAID

N = 541

Limited	35.49
Full	49.72
None	7.39
No response	7.39

TABLE II

SOURCE OF PHYSICIAN COMPETITION IN MEDICAL PRACTICE

	Rank	*% Yes*
Other physicians	1	75.60
Health Department	2	55.66
Community clinics	3	31.42
Hospital outpatient services	4	30.68
Nurse practitioners/midwives	5	21.34
Emergi-centers	6	20.00
Preferred provider organizations	7	5.74

TABLE III

REASONS FOR LIMITED PARTICIPATION

Reason	*Very Important*	*Somewhat Important*	*Not Important*	*Total Score*	*Rank*
Policy variables					
Payment too low	410	112	19	1473	1
Services not covered	256	213	71	1265	2
Unpredictable pay	245	208	88	1239	3
Complicated regulations	227	237	77	1232	4
Paperwork too long	198	269	74	1206	5
Late payments	166	248	127	1121	6
Situational variables					
Caseload discourages patients	159	227	155	1086	7
Broken appointments	142	218	181	1043	8
Type patient	116	189	236	962	9
Few eligible patients	11	54	475	616	10

most important reason for limited participation and was significantly different from all the other reasons. Services not covered and unpredictable Medicaid payment schedules were ranked second and third respectively, and were significantly different from the other seven reasons.

The first six variables ranked in Table III are policy variables. These findings support Davidson's view that policy variables more strongly influence participation than situational variables. Policy and not situational variables are the primary influences on decreased physician participation in Mississippi.

Further chi-square analysis of reasons for limited participation indicated significant differences between some physician specialities and locations. Pediatricians and obstetricians, when compared with general practice physicians, were more likely to feel that low Medicaid reimbursements would limit physicians' decisions to participate in Medicaid ($p = 0.0063$). Family practice and general practice physicians, as compared to other physicians, were less likely to feel that broken appointments would limit a doctor's decision to treat Medicaid patients ($p = 0.0001$). Comparisons between urban and rural physicians indicated three significant differences. Urban physicians were more likely to feel that paperwork ($p = 0.0108$), delays in payments ($p = 0.0270$), and complex regulations ($p = 0.02481$) would limit a physician's decision to treat Medicaid patients. These differences were found only in policy variables and not in the situational variables. These findings indicated that policy factors have a greater influence on the participation of urban rather than rural physicians.

Conclusions

Mississippi physician participation in Medicaid was found to be at a rate of 85 percent. Thirty-five percent of the physicians limit their participation in Medicaid. This is consistent with the figures presented earlier in the review of literature.

Mississippi physicians' reasons for limiting participation are the same as the reasons cited in national studies. Policy variables such as low payment, services not covered, and unpredictable payment schedules were the leading factors in the physicians' decisions regarding degree of participation. Eighty-five percent of Mississippi physicians are willing to serve Medicaid patients if such policy variables can be minimized. ★★★

Ms. Weaver: P.O. Box 4725 (39216)

Acknowledgment

This study was made possible with funding from Grant MCJ-283252-01-0 Department of Health and Human Services.

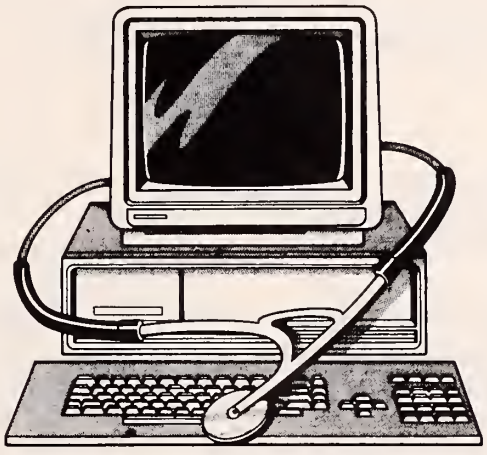
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The President Speaking

What Can We Do for MSMA?

W. JOSEPH H. BURNETT, M.D.
Oxford, Mississippi

I hope the theme for this year, rather than a statement, is more in the form of a question. "What can I do for MSMA?"

I have just this year learned that Cicero (52 B.C.) really deserves the credit for the theme presented by President Kennedy. He said,"Think not what my country can do for me — but what can I do for my country!" I propose this year that we think not what MSMA can do for us but what we can do for MSMA!

I am beginning my eighth consecutive year in service to our association — two consecutive three year terms as a trustee and now my second year as an officer. I guess without realizing it I have been part of what has been referred to as "the same old crowd which always runs things." But nothing could really be further from the truth. Your board and officers do strive to keep the House of Delegates and our membership informed and aware of changes constantly developing in medicine. But it is the House of Delegates that considers and directs the path of our association. So it is really all the membership through their elected representative in the House of Delegates who are in charge and who run things.

I am pleased with many of the accomplishments over the last several years and foresee more exciting programs on our horizon.

1. we have effected redistricting of our trustee districts;
2. we've shortened our annual convention and moved to the end of the week to more efficiently utilize time out of our offices;
3. we've incorporated MSMA Services, Inc. to accept non-dues income and preserve the tax exempt status of MSMA;
4. we've for approximately 7 consecutive years operated our budget in a profitable profile rather than repeated losses requiring additional dues;
5. we instituted a building program;
6. developed an impressive "war chest" through our PAC;
7. created MSMA Benefit Plan and Trust; and
8. investigated and organized an alternative health care delivery system.

I've only begun. These are just some of the things MSMA has done for us!

Let's look for a minute and see what we are doing for MSMA.

(continued on page 165)

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XXVII, Number 6

JUNE 1986

EDITORIALS

Where Did We Go Wrong?

There is an item in today's paper (*Commercial Appeal,* May 7, 1986) that this "health" outfit is buying five hospitals in the south, including our state, for $58,000 a bed!

My being a finance ignoramus, this choice bit of news for our patients set off a whole series of shock waves in my sclerotic brain!

These are hospitals they're talking about, not shopping centers. These centers of healing, havens of mercy, if you will, are being bandied about like Wal-Mart stores to make money for somebody's greedy pocket. The old break-even theory has fallen by the wayside. No wonder the general public looks on us, beleagured as we are, as money-grubbers, bag-men in the back alleys of the health care bonanza, creating a climate perfect for the scavenger antics of the trial lawyers, who hyena-like skirt about, waiting for their chance to snatch some of this largess.

Where did we go wrong? Think about it.

ARTHUR A. DERRICK, M.D.
Associate Editor

THE PRESIDENT SPEAKING

(Continued from page 164)

Ask yourself these questions. . . .

—Do I really encourage non-members in my area to join us?
—Do I read and follow reports about MSMA's activities?
—Do I support and appreciate our physician-directed foundation for medical care?
—Do I support MPAC?
—Did I volunteer time to go to Jackson, make legislative contacts, and promote our tort reform bills?
—Have I volunteered to serve on an MSMA or component society committee?
—Have I informed myself and investigated alternate delivery systems?
—Do I support our HMO/IPA?

How did you answer these questions? How would your society members answer them?

Have you ever really thought that others have your best interests in the front of their minds? Did you ever think St. Paul or other companies had your best interests in the front of their minds? Let me assure you that MSMA, MACM, and our other physician-directed programs have *you* and *your best* interests in the front of their minds, and they deserve your continued support!

Therefore, let's draw even closer together. For we know together we stand and divided we don't even want to talk about. So this year let's stop and become a little introspective. "What can I do for MSMA?"

I thank you for the opportunity to serve you in this office. I look forward to visiting with you during this year. I sincerely ask for your support and your prayers as I attempt to represent all of you in this capacity.

LETTERS

TO DR. BROCK:

I read your column appearing in the March 1986 issue of the JOURNAL with many feelings — pleasure, admiration and pride, to name a few.

I am pleased that you referenced our liaison meetings and our mutual concerns to provide for patient care. I admire your forthright and tenacious manner with your prescribing habits and prescriptions. And I am proud to represent an important link in the health care chain and to work with exemplary professionals like yourself.

Drug therapy via prescription management is such an elementary facet of medical care that it is too frequently treated in an almost casual and cavalier fashion. Your respect for prescription management

is so very refreshing and will light the way for others to follow.

The Mississippi Pharmacists Association looks forward to a continuing positive relationship with the Mississippi State Medical Association; we stand ready to work together toward our mutual concerns and quality patient care.

PHYLLISS M. MORET, R.PH.
Executive Director
Miss. Pharmacists Association

SIRS: Just a short note to express that I always look first for thoughts and articles by Drs. Arthur Derrick and Joseph Johnston. They so frequently seem to express how I am feeling.

JOHN M. MCRAE, M.D.
Laurel, MS

TO THE EDITORS:

This letter is in regard to the Comment of Dr. Tom Gunter, published in the March 1986 issue of the JOURNAL. I disagree with his assessment in several places.

I disagree that adoption is "an unbearable option." I believe it is certainly preferable to destruction of life. There are many childless couples desiring to adopt children who could provide a good home for them.

I disagree with the assertion that Crisis Pregnancy Centers inflict guilt. Crisis Pregnancy Centers should inform mothers about the facts of their babies to help them realize the monstrosity of elective abortion.

I disagree with the assertion that the "products of conception" should have rights inferior to their mothers. At one time, all humans were "products of conception." I find it ironic that the products of an eagle's conception are protected by law (as an endangered species) but those of human beings are not. Let's call "products of conception" by another name: baby.

The present law is unfair to everyone. That a person can be legally destroyed in one stage of life is a threat to all persons in other stages. One hundred years ago, legal abortion was unthinkable. In another hundred, will infanticide be legal?

ROBERT CAMPBELL, M.D.
Jackson, MS

Sirs: The following is a comment in response to the remarks of Dr. Tom Gunter, M.D., published in the March 1986 issue of the journal. I am submitting this for publication, and appreciate the opportunity to respond to the issues raised by Dr. Gunter.

Thank you for providing a format for consideration of these very important matters.

JOHN E. MITCHELL, M.D.
Rolling Fork, MS

COMMENT

Concerning Individual Rights

Killing a penniless black slave was once considered a lesser offense than killing a rich white landowner, since, in the opinion of our nation's courts, the slave was not a person with rights equal to the white's. Because they were in positions of lesser power and influence, various other groups — such as women — have in the past been declared by our courts to have fewer rights than those more powerful than they. Unlike those societies where one powerful group has continued to declare its own rights to be more important than any other's, however, our nation has made significant steps to ensure that every individual's rights and freedoms are given equal priority. Our nation deserves credit for its progress toward eliminating discrimination because of sex, race, or social status, and toward seeing that every individual's freedom is preserved.

Because of this freedom, it is my right to decide what is in my own best interest without having someone else's will imposed upon me. Of course, since each other individual is given equal priority, my freedom necessarily has boundaries. The limit to my freedom is the point at which my actions begin to cause harm to another individual. I have no right to take an action that will infringe upon your rights, even if I believe that the action will benefit me. This is the principle behind many of the laws governing a free society, and is the reason for prohibitions against, say, armed robbery, or rape, or contract killing. There might be potential benefit to me by carrying out one of these actions, but this is utterly beside the point. My right to choose these actions is necessarily overshadowed by the rights of those who would be harmed by my actions.

Abortion should be illegal, precisely because it

sets the rights of one group of individuals as preeminent over the rights of another, just as was previously done to other groups. The argument that the unborn child is "non-viable" is a weak attempt to justify the misuse of our own freedom at his or her expense. The fact that an unborn child cannot live outside the supportive environment of the womb has no more bearing on his or her personhood that the fact that none of us can survive underwater without support has on ours. The viability argument is a move toward the survival-of-the-fittest mentality that is the very antithesis of civilization, and, indeed, of the principles that set man above the animals.

Abortion is a personal decision only in the sense that every decision, regardless of whether or not it hurts others, is ultimately a personal one. Even legal restraints cannot always ensure that harmful actions will not be chosen by those who elect to ignore the law; laws only give an additional incentive to those whose respect for the rights of others is insufficient to keep them from acting harmfully toward them. Our courts' failure to protect the rights of the unborn, by delegating them to the status of non-persons, is a shameful regression toward some of our most shameful failures of the past.

Despite the courts' failure to extend due protection to the unborn, however, the actions of those who have resorted to violence in their efforts to prevent abortion are not to be condoned. To support this would be to use the same misguided logic that abortionists use to justify violence against the unborn in order to bring perceived benefit to the pregnant woman. The same can be said of deception in advertising by pro-life group, although one wonders which of a pro-life group and an abortion facility can say more truthfully to a pregnant woman and her unborn child, "We care — we're here to help."

Information presented by pro-life groups has been called biased and gruesome. Admittedly the presentation is often biased in the sense that it is designed to bring the recipient to a particular point of view, but is is rendered gruesome only by the gruesomeness of the abortion procedure itself. If there are misconceptions about the facts of abortion, the abortionists must share a large percentage of the blame for their unparalleled attempts to prevent expectant women from having access to all the facts. Couching behind euphemistic terms like "products of conception" may keep the picture pleasantly unclear for the woman considering an abortion, but it does not change the fact that her unborn child is about to be dismembered.

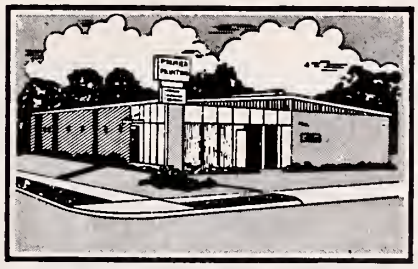
Those who are truly concerned that every one of our children be raised in a favorable environment are certainly capable of directing their efforts in more constructive ways. The difficulties that this imperfect world offers are better addressed by struggling to improve the problems of the world than by destroying the very lives we are supposedly trying to safeguard. None of us should cease in our efforts until the most defenseless among us, whether in the womb or elsewhere, are able to live without harm from those who perceive their own rights as more important than anyone else's.

JOHN E. MITCHELL, M.D.
Rolling Fork, MS

The editors invite your comments, inquiries, and suggestions. Please address letters to the Editors, *Journal of the Mississippi State Medical Association*, P.O. Box 5229, Jackson, MS 39216.

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MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 15-19, 1986, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

State and Local

Mississippi State Medical Association, 118th Annual Session, June 4-8, 1986, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, June 25-28, 1986, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, February, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, January, May, and November. H. S. Barrett, Secy., P.O. Box 1810, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington, Yazoo.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, Secy., Mail: Ms. Jenkins, P.O. Box 4053, Meridian 39305. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, Meetings scheduled quarterly. Fred G. Emrich, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, January. Charles S. Watras, 612 Summit St., Winona 38967. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, September, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. William Billington, Secy., 731 Medical Center Dr., West Point, MS 39773. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 1st Wednesday, February, April, June, August, October, December. John J. McCloskey, Secy., 3003 Short Cut Rd., Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. George R. Bush, Secy., 307 S. 13th Ave., Laurel 39440. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly
Mississippi State Medical Association
735 Riverside Drive
Jackson, MS 39216

Mississippi Chapter
American College of Surgeons
Box 5229
Jackson, MS 39216

North Mississippi Medical Center
830 Gloster Avenue
Tupelo, MS 38801

North Panola County Hospital
Drawer 160
Sardis, MS 38666

Forrest General Hospital
Box 1897
Hattiesburg, MS 39401

Singing River Hospital
P.O. Box 112
Pascagoula, MS 39567

Mississippi Baptist Hospital
1225 N. State Street
Jackson, MS 39201

Magnolia Hospital
Alcorn Drive
Corinth, MS 38834

Gulf Coast Community Hospital
4642 W. Beach Boulevard
Biloxi, MS 39531

Greenwood Leflore Hospital
1508 Leflore Avenue
Greenwood, MS 38930

Jefferson Davis Memorial Hospital
Box 1488
Natchez, MS 39120

Gulfport Memorial Hospital
4500 13th Street
Gulfport, MS 39501

King's Daughter Hospital
Box 948
Brookhaven, MS 39601

Oxford-Lafayette County Hospital
P.O. Box 946
Oxford, MS 38655

Riverside Hospital
Lakeland Drive
Jackson, MS 39208

Biloxi Regional Medical Center
1559 Lafayette St.
Biloxi, MS 39533

Jeff Anderson Regional Medical Center
2124 14th St.
Meridian, MS 39301

Northwest Mississippi Regional Medical Center
Box 1218
Clarksdale, MS 38614

Beckett Howorth Library Dedicated at UMC

Pioneer orthopedic surgeon Dr. M. Beckett Howorth was honored at the dedication of the Beckett Howorth Orthopedic Library at the University of Mississippi Medical Center April 23.

Program participants included Dr. James L. Hughes, professor of surgery (orthopedics) and chief of the Division of Orthopedics in the Department of Surgery, presiding; Dr. Howorth; Dr. Norman C. Nelson, UMC vice chancellor for health affairs and medical school dean, and Ole Miss Chancellor R. Gerald Turner. A reception and tour of the library followed the dedication ceremonies.

Dr. Howorth, is clinical professor emeritus of surgery (orthopedics), is a native of West Point. He received a baccalaureate degree in 1921 and a medical certificate in 1923 from Ole Miss. He went on to Washington University in St. Louis to complete medical school, and did his internship, residency and a fellowship in New York. He has served on the medical faculties of the Columbia College of Physicians and Surgeons and the New York University Postgraduate Medical School, on staff at the New York Orthopedic Hospital and in private practice in New Canaan, Conn. He returned to Mississippi in 1981 as clinical professor of surgery (orthopedics) at the Medical Center.

Dr. Howorth's Mississippi ''roots'' have prompted numerous gifts to the Mississippi Museum of Art and to his alma mater. He has established a trust which will provide an endowed chair for UMC — the M. Beckett Howorth, M.D., Chair in Orthopedics. Additionally the Howorths have established the Beckett Howorth Orthopedic Library Fund and the Marjorie M. Howorth Orthopedic Education for the benefit of the Department of Surgery, Division of Orthopedics.

The new Howorth libarary contains Dr. Howorth's rare orthopedic texts, orthopedic journals, slide collection, the desk and chair he has used for many years in his office — as well as a collection of works by Lester Bentley, considered one of the country's best portrait artists.

Dr. Howorth also has contributed paintings to the National Art Gallery in Washington, to the Yale Art Gallery and to the Mississippi Museum of Art — which also has established a library in his honor that contains 10 additional paintings, 200 fine art books and a number of art objects donated by Dr. Howorth.

Dr. Howorth has lectured in some 70 countries and authored five books, and written articles which have been published widely in professional orthopedic journals and in Consumers' Research, a publication for which he was a consultant for many years. He is an honorary member of the Latin American Society of Orthopedics and Traumatology and orthopedic associations in Chile, Guatemala, Turkey, South Africa and Japan. He also is a corresponding member of the New Zealand and Swiss Orthopedic Associations.



Dr. M. Beckett Howorth (right), clinical professor emeritus of surgery (orthopedics), presents a rare book to University of Mississippi Medical Center vice chancellor Dr. Norman C. Nelson, left, as a token of the presentation of the M. Beckett Howorth Orthopedic Library which Dr. and Mrs. Howorth furnished with rare books, furniture and works of art. Dr. James Hughes, center, is orthopedics division chief.

UMC OB-Gyn Alumni Association Elects Officers



New officers of the University of Mississippi Obstetrics-Gynecology Alumni Association were named at the group's annual meeting, April 17-19. Pictured from left are Dr. John E. Lindley of Meridian, vice president; Dr. Fred H. Ingram of Jackson, president; Dr. G. Rodney Meeks of Jackson, secretary-treasurer; and board member Dr. Leo Gibson of Picayune.

Wiser Society Established at UMC



The Winfred L. Wiser Society had its first official meeting during the annual University of Mississippi Medical Center Ob-Gyn Alumni meeting in April. Former and current residents in the UMC Department of Ob-Gyn wanted to honor their mentor, department chairman Dr. Winfred Wiser, (second from right) and "maintain the standards of excellence which he set." Officers of the new society are from left, Dr. Martha Brewster of New Orleans, president-elect; Dr. Charles Wooley, senior resident, secretary-treasurer. Dr. Frank Page, right, of Birmingham, Alabama, is president. The founding members of the society presented Dr. Wiser with a plaque in appreciation for "his excellent teaching and career guidance."


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NEW MEMBERS

AL-MEFTY, OSSAMA, Jackson. Born Damascus, Syria, April 20, 1947; M.D., Damascus University Medical School, July 1972; interned, one year, Huron Road Hospital, Cleveland, OH; general surgery residency, Medical College of Ohio, Toledo, 1973-74; neurosurgery residency, West Virginia University Medical Center, Morgantown, July 1974-June 1978; elected by Central Medical Society.

BALLARD, JAMES LEE, JR., Tupelo. Born Tupelo, MS, Dec. 7, 1938; M.D., University of Mississippi School of Medicine, Jackson, 1964; interned, one year, University Medical Center, Jackson; dermatology residency, Arkansas Medical Center, Little Rock, 1965-68; elected by Northeast Mississippi Medical Society.

GERKEN, MAXINE V., Jackson. Born Sioux Falls, SD, May 24, 1952; M.D., Creighton University School of Medicine, Omaha, NE 1978; interned University Medical Center, Jackson, MS, one year; general surgery residency, same, 1979-83; thoracic surgery residency, same, 1983-85; elected by Central Medical Society.

HILSMAN, GRAY, Jackson. Born Jackson, MS, Aug. 10, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned and psychiatry residency, University Medical Center, Jackson, 1975-78; elected by Central Medical Society.

HUDSON, JIM K., III, Ocean Springs. Born Memphis, Oct. 19, 1954; M.D., University of Tennessee Center for Health Services, Memphis, 1980; interned Baptist Memorial Hospital, Memphis, 1980-81; surgery residency, University of Tennessee, 1981-82; orthopedic residency, Campbell Foundation, Memphis, 1983-85; elected by Singing River Medical Society.

JACKSON, RICHARD T., Jackson. Born Memphis, Nov. 17, 1955; M.D., University of Mississippi School of Medicine, Jackson, 1981; interned and internal medicine residency, University Medical Center, Jackson, 1981-85; elected by Central Medical Society.

KATZ, HOWARD T., Jackson. Born Memphis, March 8, 1956; M.D., University of Tennessee Center for the Health Sciences, Memphis, 1982; interned and physical medicine and rehabilitation residency, Tufts University, Boston, 1982-85; elected by Central Medical Society.

KEES, CLARENCE JAMES, III, Jackson. Born Magee, MS, June 8, 1938; M.D., University of Mississippi School of Medicine, 1964; interned, one year, University of Alabama, Birmington, 1964-65; radiology residency, Barnes Hospital, St. Louis, MO 1965-68; elected by Central Medical Society.

LAND, ROBERT D., Meridian. Born Cyril, AL, Jan. 26, 1934; M.D., Medical College of Alabama, Birmingham, 1960; interned and one year family practice residency, Medical Center, Columbus, GA 1960-61 and 1963-64; general surgery residency, Carraway Methodist Medical Center, Birmingham, 1967-70; elected by East Mississippi Medical Society.

LEBLANC, MICHAEL H., Jackson. Born Birmingham, Oct. 19, 1950; M.D., University of Alabama School of Medicine, Birmingham, 1975; interned, Children's Medical Center, Cincinnati, OH, 1975-76; pediatric residency, University of Cincinnatti, OH 1975-78; neonatology fellowship, same, 1978-81; elected by Central Medical Society.

MCGRAW, DAVID B., Woodville. Born Centreville, MS, Jan. 21, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned, University Medical Center, Jackson, one year; elected by Amite-Wilkerson Medical Society.

MILLER, JIMMY D., Jackson. Born Tupelo, MS, Sept. 19, 1954; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned, surgery residency, and neurosurgery residency, University Medical Center, Jackson 1979-85; elected by Central Medical Society.

MIXON, JAMES H., Biloxi. Born Philadelphia, PA, April 14, 1944; M.D., Temple University School of Medicine, Philadelphia, PA, 1979; interned Eastern Virginia, Norfolk, VA, one year; family practice residency, same, 1980-82; elected by Coast Counties Medical Society.

NAYAK, MINA C., Laurel. Born India May 8, 1948; M.D., B.J. Medical College Civil Hospital, Ahmedabad, India 1972; interned University Medical Center, Lafayette, LA, one year; ob-gyn residency, LSU, New Orleans, LA,1976-79; elected by South Mississippi Medical Society.

PUCKETT, CRIS G., Jackson. Born Wooster, OH, Sept. 8, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned and pediatric residency, University Medical Center, Jackson, 1980-83; neonatology fellowship, University of Texas, Houston, TX, 1983-85; elected by Central Medical Society.

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While many clinical laboratories still report 250 mg/dL as "normal" cholesterol, the NIH Consensus Development Conference Statement on Cholesterol and Heart Disease[3] stated that any level above 220 mg/dL is associated with a significantly increased risk of coronary heart disease.

You need to know, because high cholesterol parallels high blood pressure as a CHD risk factor.

Epidemiological studies and large-scale prevention trials have indicated that as with blood pressure, serum cholesterol levels are proportionately related to CHD risk. Specifically, *"...for every 10 mmHg rise in pressure, there appears to be about a 30% rise in cardiovascular risk."*[4] *"...for every one percent you go up the American cholesterol scale, your subsequent rate of heart attack rises two to three percent."*[5]

And although the specific impact on CHD has not been determined, we know that many of the principal agents used to lower blood pressure actually increase cholesterol.

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While Wytensin is not a cholesterol-lowering agent and is not indicated for the treatment of hyperlipidemia, in controlled clinical trials[6] it caused a slight, sustained decrease in total cholesterol without reducing the HDL fraction or altering serum triglycerides.

At the same time, Wytensin lowered blood pressure as effectively as hydrochlorothiazide, propranolol, clonidine or methyldopa. Drowsiness and/or dry mouth, the most frequent side effects noted with Wytensin, usually diminish or disappear over time. In fact, in double-blind studies to date, discontinuance of therapy for all side effects occurred in about 13% of patients.



Wytensin®
(guanabenz acetate)

Antihypertensive therapy that does not increase cholesterol

See important information on following page.

References: 1. Glueck CJ: Remarks in the symposium, *Blood Pressure, Cholesterol and Coronary Heart Disease*, Washington, D.C., March 31, 1985. 2. *The Framingham Study, An epidemiological investigation of cardiovascular disease*, Section 28, U.S. Dept. of Health, Education, and Welfare. 3. National Institutes of Health Consensus Development Conferance Statement, 1984: Vol 5, No 7, p 4. 4. Chobanian AV: The influenca of hypertansion and other hemodynamic factors in atherogenesis. *Progress in Cardiovascular Diseases, XXVI* (3): 177, Nov/Dec, 1983. 5. Castelli WP: Remarks in the symposium, *Blood Pressure, Cholesterol and Coronary Heart Disease*, Washington, D.C., March 31, 1985. 6. Data on file, Wyeth Laboratories.

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WyTensin®
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Antihypertensive therapy that does not increase cholesterol

Brief Summary

Before prescribing, consult the complete package circular.

Indications and Usage: Treatment of hypertension, alone or in combination with a thiazide diuretic.

Contraindication: Known sensitivity to the drug.

Precautions: 1. Sedation. Causes sedation or drowsiness in a large fraction of patients. When used with centrally active depressants, e.g., phenothiazines, barbiturates and benzodiazepines, consider potential for additive sedative effects. 2. Patients with vascular insufficiency. Like other antihypertensives use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease, or severe hepatic or renal failure. 3. Rebound. Sudden cessation of therapy with central alpha agonists like **Wytensin** may rarely result in "overshoot" hypertension and more commonly produces increase in serum catecholamines and subjective symptomatology.

INFORMATION FOR PATIENTS: Advise patients on **Wytensin** to exercise caution when operating dangerous machinery or motor vehicles until it is determined they do not become drowsy or dizzy. Warn patients that tolerance for alcohol and other CNS depressants may be diminished. Advise patients not to discontinue therapy abruptly.

LAB TESTS: In clinical trials, no clinically significant lab test abnormalities were identified during acute or chronic therapy. Tests included CBC, urinalysis, electrolytes, SGOT, bilirubin, alkaline phosphatase, uric acid, BUN, creatinine, glucose, calcium, phosphorus, total protein, and Coombs' test. During long-term use there was small decrease in serum cholesterol and total triglycerides without change in high-density lipoprotein fraction. In rare instances occasional nonprogressive increase in liver enzymes was observed, but no clinical evidence of hepatic disease.

DRUG INTERACTIONS: **Wytensin** was not demonstrated to cause drug interactions when given with other drugs, e.g., digitalis, diuretics, analgesics, anxiolytics, and antiinflammatory or antiinfective agents, in clinical trials. However, potential for increased sedation when given concomitantly with CNS depressants should be noted.

DRUG/LAB TEST INTERACTIONS: No lab test abnormalities were identified with **Wytensin** use.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: No evidence of carcinogenic potential emerged in rats during a two-year oral study with **Wytensin** at up to 9.5 mg/kg/day, i.e., about 10 times maximum recommended human dose. In the Salmonella microsome mutagenicity (Ames) test system, **Wytensin** at 200-500 mcg per plate or at 30-50 mcg/ml in suspension gave dose-related increases in number of mutants in one (TA 1537) of five *Salmonella typhimurium* strains with or without inclusion of rat liver microsomes. No mutagenic activity was seen at doses up to those which inhibit growth in the eukaryotic microorganism, *Schizosaccharomyces pombe*, or in Chinese hamster ovary cells at doses up to those lethal to the cells in culture. In another eukaryotic system, *Saccharomyces cerevisiae*, **Wytensin** produced no activity in an assay measuring induction of repairable DNA damage. Reproductive studies showed a decreased pregnancy rate in rats given high oral doses (9.6 mg/kg), suggesting impairment of fertility. Fertility of treated males (9.6 mg/kg) may also have been affected, as suggested by decreased pregnancy rate of mates, even though females received drug only during last third of pregnancy.

PREGNANCY: Pregnancy Category C. WYTENSIN® MAY HAVE ADVERSE EFFECTS ON FETUS WHEN ADMINISTERED TO PREGNANT WOMEN. A teratology study in mice indicated possible increase in skeletal abnormalities when **Wytensin** is given orally at doses 3 to 6 times maximum recommended human dose of 1.0 mg/kg. These abnormalities, principally costal and vertebral, were not noted in similar studies in rats and rabbits. However, increased fetal loss has been observed after oral **Wytensin** given to pregnant rats (14 mg/kg) and rabbits (20 mg/kg). Reproductive studies in rats have shown slightly decreased live-birth indices, decreased fetal survival rate, and decreased pup body weight at oral doses of 6.4 and 9.6 mg/kg. There are no adequate, well-controlled studies in pregnant women. **Wytensin** should be used during pregnancy only if potential benefit justifies potential risk to fetus.

NURSING MOTHERS: Because no information is available on **Wytensin** excretion in human milk, it should not be given to nursing mothers.

PEDIATRIC USE: Safety and effectiveness in children less than 12 years of age have not been demonstrated, use in this age group cannot be recommended.

Adverse Reactions: Incidence of adverse effects was ascertained from controlled clinical studies in U.S. and is based on data from 859 patients on **Wytensin** for up to 3 years. There is some evidence that side effects are dose-related. Following table shows incidence of adverse effects in at least 5% of patients in study comparing **Wytensin** to placebo, at starting dose of 8 mg b.i.d.

Adverse Effect	Placebo (%) n = 102	**Wytensin** (%) n = 109
Dry mouth	*	28
Drowsiness or sedation	12	39
Dizziness	*	17
Weakness	*	10
Headache	6	5

In other controlled clinical trials at starting dose of 16 mg/day in 476 patients, incidence of dry mouth was slightly higher (38%) and dizziness was slightly lower (12%), but incidence of most frequent adverse effects was similar to placebo-controlled trial. Although these side effects were not serious, they led to discontinuation of treatment about 15% of the time. In more recent studies using an initial dose of 8 mg/day in 274 patients, incidence of drowsiness or sedation was lower, about 20%. Other adverse effects reported during clinical trials but not clearly distinguishable from placebo effects and occurring with frequency of 3% or less. Cardiovascular—chest pain, edema, arrhythmias, palpitations. Gastrointestinal—nausea, epigastric pain, diarrhea, vomiting, constipation, abdominal discomfort. Central nervous system—anxiety, ataxia, depression, sleep disturbances. ENT disorders—nasal congestion. Eye disorders—blurring of vision. Musculoskeletal—aches in extremities, muscle aches. Respiratory—dyspnea. Dermatologic—rash, pruritus. Urogenital—urinary frequency, disturbances of sexual function. Other—gynecomastia, taste disorders.

Drug Abuse and Dependence: No dependence or abuse has been reported.

Overdosage: Accidental ingestion caused hypotension, somnolence, lethargy, irritability, miosis, and bradycardia in two children aged one and three years. Gastric lavage and pressor substances, fluids, and oral activated charcoal resulted in complete and uneventful recovery within 12 hours in both. Since experience with accidental overdosage is limited, suggested treatment is mainly supportive while drug is being eliminated and until patient is no longer symptomatic. Vital signs and fluid balance should be carefully monitored. Adequate airway should be maintained and, if indicated, assisted respiration instituted. No data are available on **Wytensin** dialyzability.

Dosage and Administration: Individualize dosage. A starting dose of 4 mg b.i.d. is recommended, whether used alone or with a thiazide diuretic. Dosage may be increased in increments of 4 to 8 mg/day every one to two weeks, depending on response. Maximum dose studied has been 32 mg b.i.d., but doses this high are rarely needed.

How Supplied: (guanabenz acetate) Tablets, 4 mg, bottles of 100 and 500; 8 mg and 16 mg, bottles of 100.

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12. I'm allergic to flowering magnolia."



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NEW MEMBERS/Continued

RANDOLPH, BRUCE W., West Point. Born Live Oak, FL, Aug. 24, 1958; M.D., University of Florida College of Medicine, Gainesville, FL, 1984; interned one year, University of Arkansas, Fort Smith; elected by Prairie Medical Society.

SIMMONS, A. LARRY, Jackson. Born McComb, MS, Sept. 10, 1950; M.D. University of Mississippi School of Medicine, Jackson, MS, 1977; interned Arkansas Childrens Hospital, Little Rock, one year; pediatric residency, University Arkansas, Little Rock, 1968-80; elected by Central Medical Society.

THOMAS, DENNIS R., Pascagoula. Born Fort Wayne, IN. Oct. 16, 1951; M.D. Indiana University School of Medicine, Indianapolis, IN, 1979; interned University of South Carolina, one year; medicine residency, same 1979-81; cardiology fellowship, St. Francis Hospital, Hartford, CN, 1981-83; elected by Singing River Medical Society.

WILLIAMS, JESSE C., Columbus. Born Poplarville, MS, Sept. 13, 1954; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned and medicine residency, Howard University Hospital, Washington, DC 1980-82; elected by Prairie Medical Society.

DEATHS

SIMMONS, WILLIAM C., Bay Springs. Born Louis, MS, Nov. 24, 1983; University of Tennessee School of Medicine, Memphis, 1927; one year internship, Memphis Charity Hospital; died Jan. 2, 1986, age 94.

HOLLINGSWORTH, JEFFERSON F., Jackson. Born Meridian, MS, July 6, 1943; M.D., Tulane University School of Medicine, New Orleans, 1968; interned Duke University, Durham, NC, one year; surgery residency, Duke University, 1969-70; surgery residency, National Institutions of Health, Bethesda, MD, 1970-72; surgery residency and cardiovascular surgery, Stanford University, Palo Alto, CA, 1972-75; died March 11, 1986, age 42.

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PERSONALS

ORLANDO ANDY of UMC presented a paper at the Neurosurgical Society of America meeting in Point Clear, Alabama.

GEORGE W. BALL of Jackson appeared on Hinds General Hospital's "Health Matters" program on WAPT.

G. WILLIAM BATES of UMC was visiting speaker for the Mecklenberg Ob-Gyn Society meeting in Charlotte, North Carolina.

JOHN R. BISE of Jackson attended the Clinical Meeting of the American Society for Colposcopy and Cervical Pathology and the Biennial Clinical Meeting of the Gynecologic Laser Society in Boston.

WALLACE E. CALDWELL of Jackson has been named vice chairman of the Guardian Society of the University of Mississippi Alumni Association.

WINSTON CAMERON of Philadelphia was guest speaker at a recent meeting of the Neshoba County General Hospital medical staff.

WEBSTER CLEVELAND of Booneville recently was honored by the local medical staff and Baptist Memorial Hospital for his 30 years of medical service.

C. RON CANNON of Jackson was speaker for the Crusade Kick-Off for the American Cancer Society for Hinds and Madison counties.

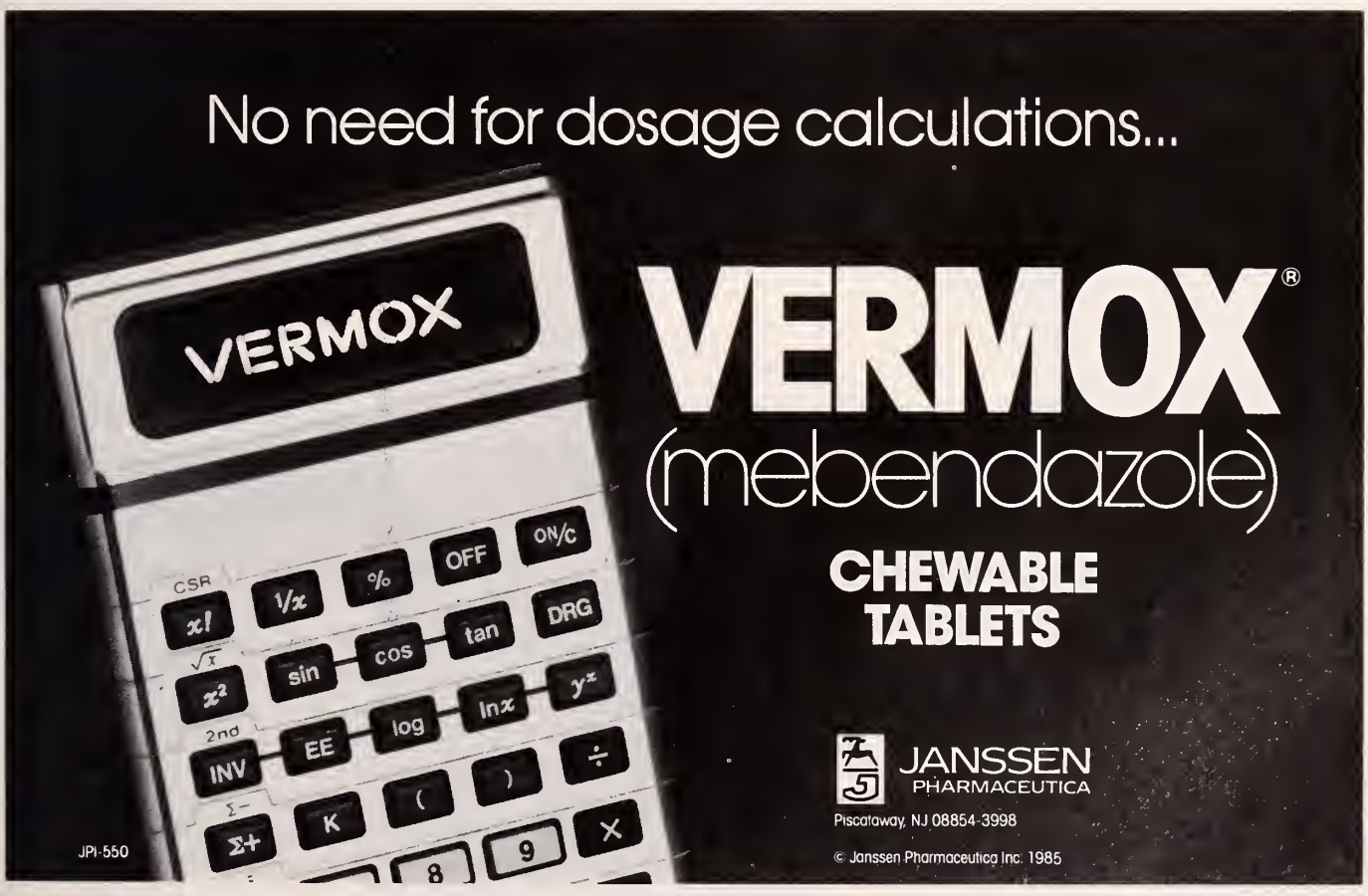
WALLACE CONERLY of UMC was guest speaker for the Central New York Chapter of the New York State Society for Respiratory Therapy's 18th annual seminar in Syracuse.

OWEN EVANS of UMC was guest lecturer for meetings of the Baton Rouge Pediatricians and Baton Rouge Neurology Group.

CARL EVERS of UMC was guest speaker at the Alpha Epsilon Delta initiation banquet at Delta State University.

JUDY GEARHART of UMC was guest speaker at the University of Florida Family Practice Review in Orlando.

ALLEN GERSH of Hattiesburg has been named a founding board member of the National Dialysis Association.



PERSONALS/Continued

ED HILL of Hollandale was recently appointed to the Commission on Membership and Member Services of the American Academy of Family Physicians.

HERBERT LANGFORD was guest speaker at the First National Interdisciplinary Conference on Hypertension in Blacks in Atlanta and presented a paper at the 26th annual Conference on Cardiovascular Disease Epidemiology in San Francisco.

PATRICK LEHAN of UMC attended a board of governors meeting of the American College of Cardiology in Atlanta.

MYRON W. LOCKEY of Jackson has been elected delegate from the La.-Miss. O & O Society to the American Academy of Otolaryngology-Head and Neck Surgery.

TOM LOUIS of Jackson was elected to a two-year term as Councillor of the La.-Miss. O & O Society.

J. KEITH MANSEL, JOHN E. STUDDARD and BARRY L. WHITES announce their association and the formation of The Pulmonary Clinic, 2660 Ridgewood Road in Jackson.

DON Q. MITCHELL of Jackson was appointed to the Board of Governors of the American Association of Certified Allergists at its 17th annual convention held recently in New Orleans.

WILSON E. MOAK has been re-elected secretary-treasurer of the La.-Miss. O & O Society.

ROBERT J. MOORHEAD of Yazoo City announces his retirement from the practice of medicine and surgery.

WILLIAM C. NICHOLAS of UMC attended the American Diabetes Association's National Committee Meeting in Washington, DC and also spoke recently at Biloxi Medical Center and Vicksburg Clinic.

SESHADRI RAJU of UMC presented a paper at the Southern Association for Vascular Surgery in Puerto Rico.

RANDOLPH J. ROSS of Hattiesburg has been appointed a clinical investigator for the Southeastern Cancer Study Group — Urology Division.

HENRY SANDERS of McComb was guest lecturer at the University of Tennessee's Ophthalmology Society meeting in Vail-Beaver Creek, Colorado.

JOHN J. WHITE of Jackson was elevated to the presidency of the La.-Miss. O & O Society.

ROBERT L. WILLIAMS announces the opening of his practice of pediatrics at 1153 Howard Avenue in Biloxi.

WINFRED WISER of UMC made a presentation at the Conference on Aging in Biloxi.

Medico-Legal Brief

Blue Shield Must Pay For Chiropractic Treatment

Refusal by Blue Shield to reimburse a member for treatment furnished by a chiropractor violated the Unfair Practices and Frauds Act, a Missouri appellate court ruled.

A patient filed suit after his bill was rejected on the grounds that chiropractic manipulations were not included in the Blue Shield schedule of covered benefits. A trial court ruled in favor of Blue Shield, and the patient appealed.

On appeal, the appellate court said that under Missouri law Blue Shield could not make or permit unfair discrimination by restricting a member's freedom of choice concerning treatment by practitioners. Blue Shield could not refuse reimbursement for treatment of a covered illness or injury merely because the health care provider was a chiropractor, the court said. The statute included chiropractors on a list of practitioners from whom members had freedom of choice to seek services.

The court remanded the case to the trial court for entry of a declaratory judgment in favor of the patient that Blue Shield violated the Act. — *Klinginsmith v. Missouri Department of Consumer Affairs, Regulation and Licensing, Division of Insurance*, 693 S.W.2d 226 (Mo.Ct. of App., May 14, 1985; rehearing denied, July 2, 1985; transfer denied, Aug. 7, 1985)

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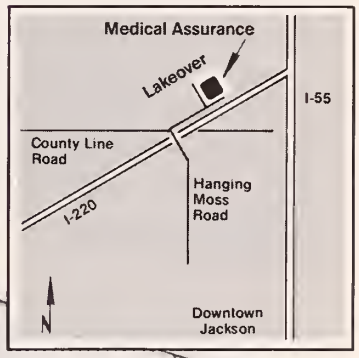
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The Mississippi Disability Determination Services now has a program available for medical society meetings and hospital staff meetings. The purpose of this program is to explain the Social Security Disability program, the medical documentation requirements, and how the disability determination process works. Any group interested in this presentation should also contact the Medical Relations Office.

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Index to Advertisers

Automated Health Systems ..... **second cover**
Avanti 171
Ayerst Laboratories **10A, 10B, 10C, 10D**

Canton Exchange Bank 173
Curtis 1000 Information Systems 163

Disability Determination Services 178

Harreld Chevrolet 173
F. W. Hebert Hospital **6**

Janssen Pharmaceutica 176

Knoll Pharmaceutical 160B, 160C, 160D

Eli Lilly and Company **6B**

Medical Assurance Co. of Miss. 177
MSMA Benefit Plan and Trust **8**

Premier Printing 167

Roche Laboratories ..... **third, fourth covers**

Smith Kline and French **6A**, 160A

The Upjohn Company 172A
U.S. Air Force **4**
U.S. Army Reserve 158

Jon Wimbish 174
Wyeth Laboratories 172B, 172C, 172D

Thomas Yates & Co. **10**



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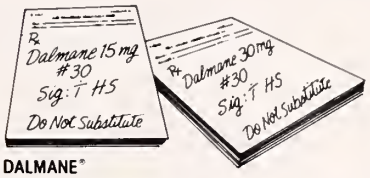
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References: **1.** Kales J, *et al. Clin Pharmacol Ther 12* 691-697, Jul-Aug 1971. **2.** Kales A, *et al. Clin Pharmacol Ther 18*.356-363, Sep 1975 **3.** Kales A, *et al. Clin Pharmacol Ther 19*.576-583, May 1976 **4.** Kales A, *et al. Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR. *J Am Geriatr Soc 27*.541-546, Dec 1979 **6.** Dement WC, *et al: Behav Med*, pp. 25-31, Oct 1978 **7.** Kales A, Kales JD: *J Clin Psychopharmacol 3*.140-150, Apr 1983 **8.** Tennont FS, *et al*: Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984 **9.** Greenblott DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977.



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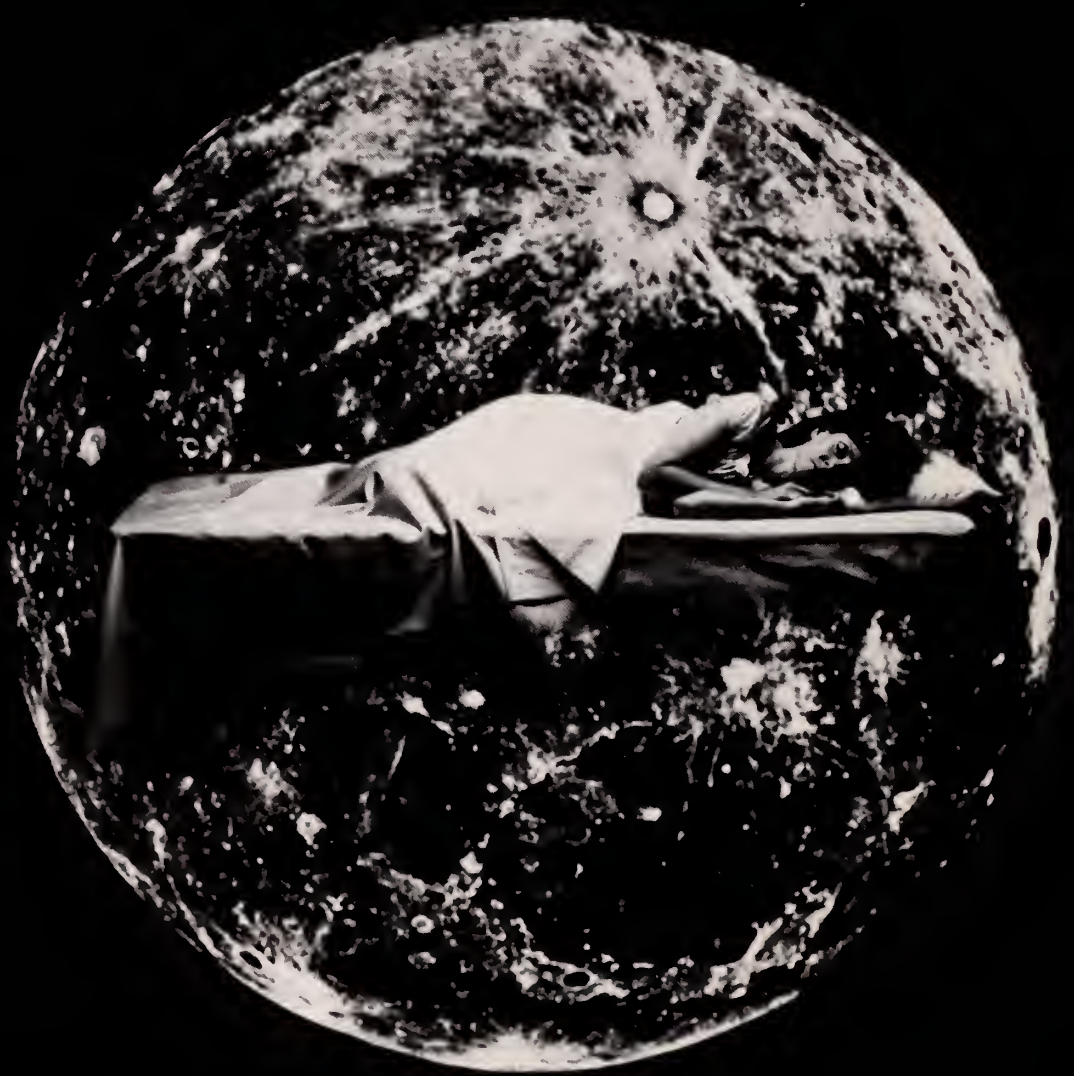
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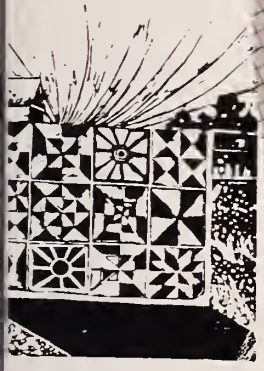
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JOURNAL
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JULY 1986

Highlights of the
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CONTENTS

ORIGINAL PAPERS

A Unique Cervical Spine Fracture-Dislocation: Case Report — **179** Rodney E. Frothingham, M.D., Alexandre Solomon, M.D. and Robert Z. Fialkow, M.D.

Esophageal Variceal Sclerotherapy: University of Mississippi Medical Center and Jackson Veterans Administration Medical Center Experience — 1980-1984 — **183** Samuel C. Pace, M.D. and James L. Achord, M.D.

EDITORIAL

High Tech in Rural Mississippi — **189** Joseph E. Johnston, M.D.

THIS MONTH

The Cream Always Rises to the Top — **188** The President Speaking

Highlights of 118th Annual Session — **191** Medical Organization

204 Medico-Legal Brief

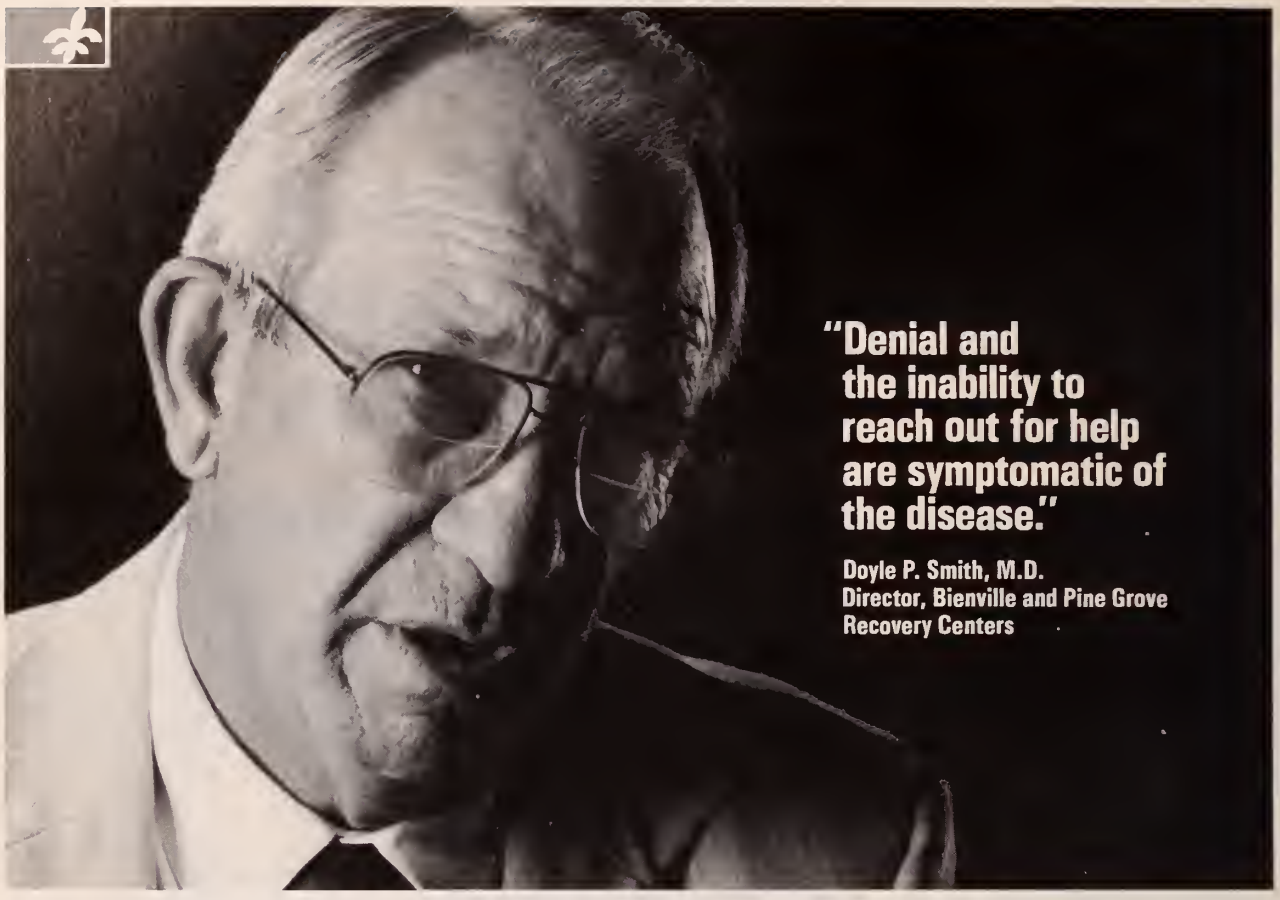
205 Personals

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NEWSLETTER

July 1986

Dear Doctor:

A task force of health professionals, educators, state officials and parents began work last month to develop a health curriculum for Mississippi's public schools, a program long recommended by MSMA. Sex education and drug and alcohol information are expected to be included in the proposed curriculum which is to be presented to the Board of Education by January 1987.

> Teenage births account for 21% of all Mississippi births, making this state's teen birth percentage one of the highest in the nation. Of the 9,298 births to Mississippi teenagers in 1984, 6,147 were to unmarried mothers. While panel members expect the sex education proposal to be controversial in this state, a 1985 poll indicates that nationwide, 84% of American adults consider teenage pregnancy a serious national problem and the same number agree that sex education should be taught in schools.
>
> MSMA members appointed to the advisory committee are: Drs. J. Ed Hill of Hollandale, Cliff Seyler of Pascagoula, William F. Sistrunk of Jackson, and D. P. Smith of Hattiesburg.

The first nationwide program on sexuality and contraception is being offered to high schools in an effort to combat the epidemic of teen pregnancies. "Straight Talk," a multimedia program featuring the teenage stars of the popular TV show "Kate and Allie," is being launched in 650 schools in 11 major cities across the country. Eventually the program will be expanded to include schools in all 50 states. More than 1.1 million pregnancies occur to American teenagers every year, and about half of those end in miscarriages or abortions. More than 500,000 babies are born every year to teenage mothers. Trends indicate that 40% of today's 14-year-old girls will be pregnant at least once by age 20. The U. S. is the only developed country where teenage pregnancy has been increasing. The U.S. teenage pregnancy rate is twice that of Canada, England or France and seven times that of the Netherlands.

Sincerely,

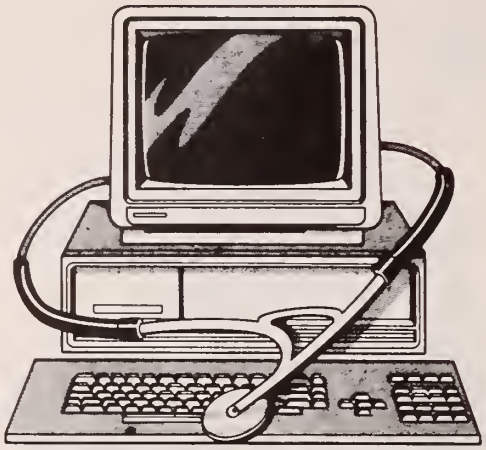
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DATELINE

Exhibitors Award Prizes At 118th Annual Session

Jackson, MS - Five MSMA members won prizes at the 118th Annual Session's Technical Exhibit. Holiday Inn Crowne Plaza presented a trip to New Orleans to Dr. Joseph Mitchell of Gulfport. Drs. Bill Bowlus and Howard Freeman of Jackson won Sony TV sets from Bedsole Medical Co. Dr. Bowlus and Dr. A. T. Tatum of Petal received cassette recorders from Lanier Business Products. Dr. Mal Morgan of Natchez won the $500 cash attendance prize.

Medical Assistants Schedule Workshops

Jackson, MS - Medical assistants can receive instruction in CPT-4 and ICD-9 coding at workshops scheduled for July 31-August 1 in Tupelo. The sessions, sponsored by the Mississippi Society of Medical Assistants, will be held at the Ramada Inn Convention Center. Fee is $50 for society members and $75 for non-members. Registration is limited. For information, contact Linda McMinn, Rt. 1, Box 914, Mooreville, MS 38857.

More States Enact Safety Belt Use Laws

Washington, DC - A total of 160 million Americans are covered by safety belt use laws now that statutes took effect July 1 in six more states. On that date Kansas, Idaho, Iowa, Louisiana, Florida and Maryland joined 20 other states with safety belt use laws. A recent nationwide poll revealed that 71% of the adults in the United States favor safety belt use laws for drivers and front seat passengers.

Medicare Assignment Mandatory for Licensure

Chicago, IL - A Boston federal court judge has upheld a Massachusetts law requiring physicians to accept Medicare assignment as a condition of licensure. The American Medical Association had joined the Massachusetts Medical Society in fighting the state law, and both groups will appeal the ruling. The AMA sees the case as a test of the ways in which states may involve themselves in the administration of Medicare.

Florida Adopts Insurance Tort Reform

Chicago, IL - Legislation adopted in Florida mandates a 40% rate rollback, significant insurance industry restrictions, and tort reforms that have been praised by physician, attorney and consumer groups. Among tort changes are: a $450,000 cap on non-economic damages; elimination of joint and several liability in certain cases; itemization of damages in verdicts; and periodic payments for future economic damages over $250,000.

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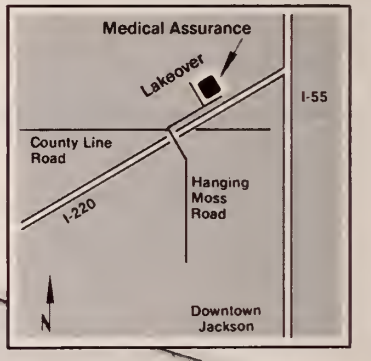
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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
July 1986, XXVII, Number 7

ORIGINAL PAPERS

A Unique Cervical Spine Fracture-Dislocation: Case Report

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Greenville, Mississippi

The authors present a case of an elderly patient who suffered what initially appeared to be a minor accident, but was subsequently found to have a life-threatening cervical spine fracture-dislocation.

CERVICAL SPINE INJURIES are one of the more common injuries encountered in medical practice. Occasionally, the severity of the injury is greater than first thought because of the apparent triviality of the injury. This is particularly true when dealing with patients with underlying bone disease who are predisposed to fractures. The case presented is of an elderly dialysis patient who suffered what initially appeared to be a minor accident which was subsequently seen to have resulted in a life-threatening cervical spine fracture-dislocation.

Case Report

The patient was diagnosed as having sarcoidosis in 1959 when she was 42 years old. Because of the proteinuria, a renal biopsy was obtained in 1969 and membranous glomerulonephritis was found. She subsequently developed end stage renal disease and in 1978 hemodialysis was begun. In October 1982, the patient was involved in a minor auto accident and hurt her right foot, sustaining fractures to the right second and third metatarsals. This was treated with cast placement. A second automobile accident in January 1983, resulted in an incomplete fracture of her right hip which was treated conservatively. Besides the propensity towards fractures, the patient presented other evidence of significant renal osteodystrophy. The patient's alkaline phosphatase was routinely 10 to 20 times normal; her serum PTH levels were at least 20 times normal; and her metabolic bone surveys revealed osteopenia and changes of secondary hyperparathyroidism. The patient was advised to have a parathyroidectomy, but she refused.

On August 29, 1985 the patient grasped a door knob, and as she pulled to open the door, the knob came loose in her hand, causing her to lose her balance, falling backward and striking her head. There was no loss of consciousness. The next day she was seen by her physician. She complained of being sore "all over" but was unable to localize any particular place. On physical examination, she was tender to palpation in her neck, left shoulder, back, hip and left leg, but range of motion was satisfactory and neurologic exam was unremarkable. She was carefully observed over the next month, and throughout, her main complaint was discomfort

From the Departments of Neurosurgery (Drs. Frothingham and Solomon) and Nephrology (Dr. Fialkow) of Delta Medical Center, Greenville, MS.

in her left hip. Approximately one month after her fall she noted increased pain in her neck. Her local physician obtained cervical spine films, which revealed a C5-6 fracture-dislocation (see Figures 2A and 2B). She was immediately referred to Delta Medical Center.

Fortunately, an x-ray of the cervical spine had been obtained some time earlier (see Figure 1), which revealed only C5-6 degenerative change, further substantiating the traumatic nature of the current fracture.

The patient was placed in skeletal traction with Gardner-Wells tongs and progressive weight was added in an attempt to reduce the fracture-dislocation (see Figures 3A and 3B).

A CT scan was obtained, confirming the magnitude of the spinal canal compromise at the C5 level, even after maximal reduction (see Figure 5).



Figure 1. X-ray of cervical spine as it appeared prior to current surgery.

Operative Technique

The anterior approach was selected to both decompress the spinal canal and stabilize the vertebral column. At the time of surgery, it became clear that the fracture was much more complex than originally anticipated. Following closed reduction, the body of C4 had slipped forward on the vertebral body of C5, thereby "locking" C5 behind both C4 and C6 (see Figures 3A and 3B). The remains of the vertebral body of C5 were laboriously removed to decompress the spinal cord. The body of C4 was found to be fractured, as well. The decision was made to avoid bone grafting. Rather, a small metal plate, screws and pins were used to strut from C3 through C6. The entire area was then covered with methylmethacrylate (shaded area, Figure 4B) to stabilize firmly (see Figures 4A and 4B).

Postoperative Course

The patient recovered well from surgery, having no neurological deficit. By the second postoperative



Figure 2A. X-ray of the cervical spine at the time of admission.



Figure 3A. X-ray of the cervical spine following closed reduction with Gardner-Wells tongs.



Figure 5. CT scan of the cervical spine at the level of maximal spinal canal compromise (C5).



Figure 4A. X-ray of the postoperative cervical spine.

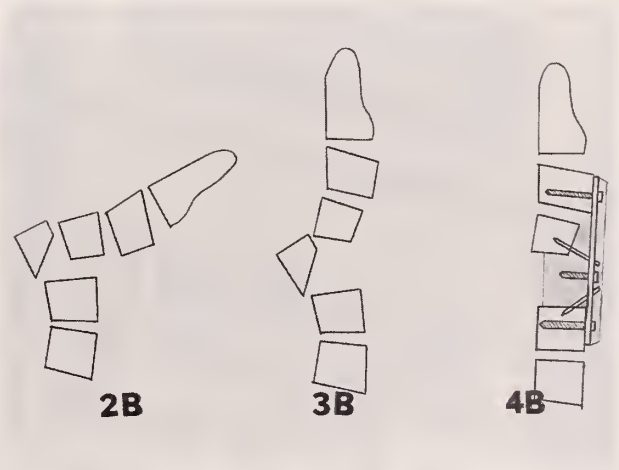


Figure 6. Diagrammatic representation of the fracture-dislocation before reduction (2B), after closed reduction (3B), and after surgical decompression and stabilization (4B).

day, the patient was taking oral liquids, smiling, talking, and having surprisingly few complaints.

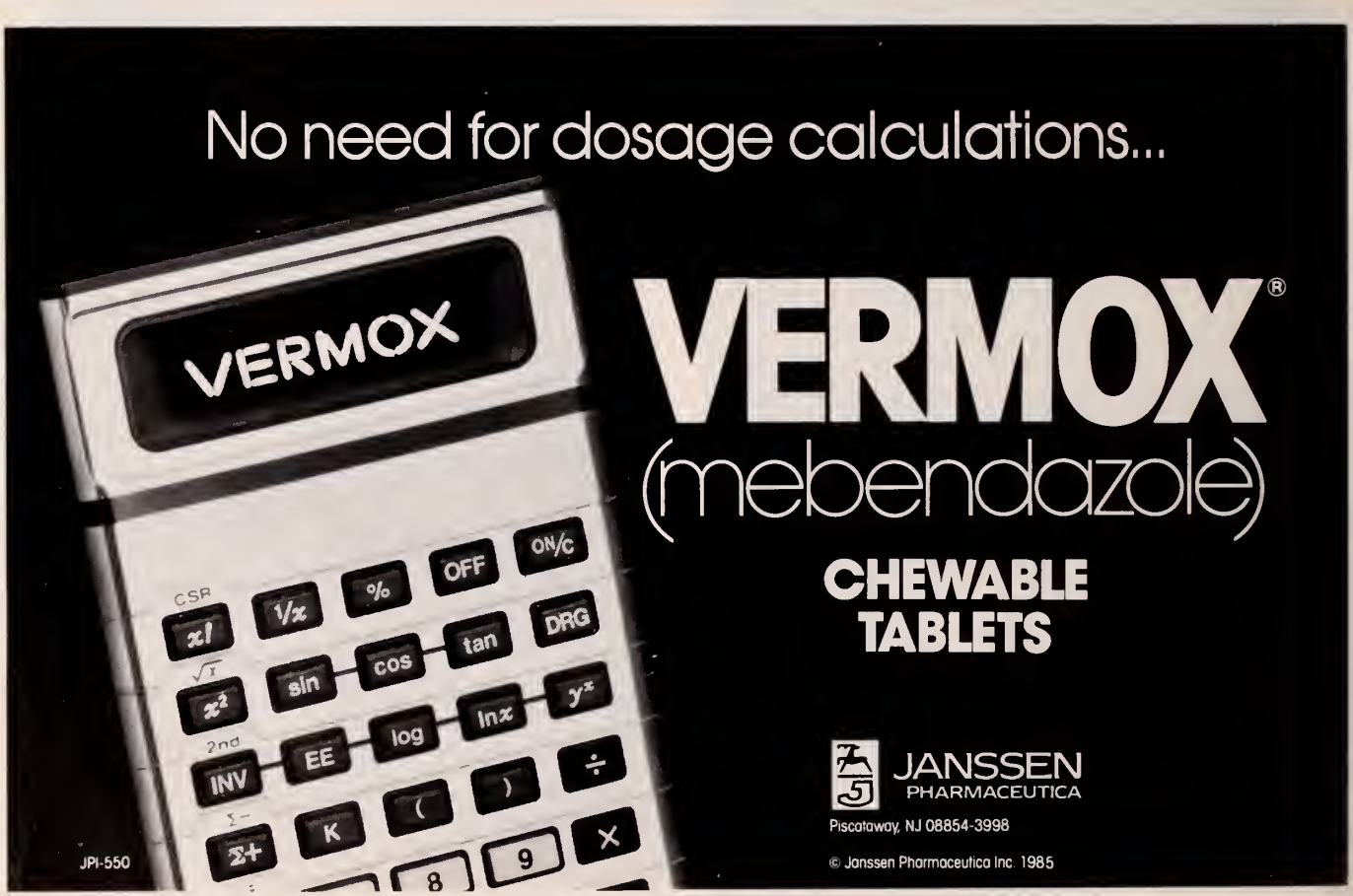
On the fourth postoperative day she suffered a cardiopulmonary arrest. Despite aggressive attempts at resuscitation, she expired. Despite this tragic outcome, the operative technique proved very effective for both decompression and stabilization of the unusual fracture.

Discussion

This unique fracture-dislocation of the cervical spine fracture required a complex anterior surgical approach for decompression of the spinal canal and cord followed by stabilization, utilizing orthopedic "hardware" and methylmethacrylate.

The severity of this patient's lesion resulted from what was first believed to be a minor degree of trauma. Remarkably, this patient remained neurologically intact an entire month following the accident. We feel that physicians dealing with patients who are at increased risk of fractures must maintain a high degree of suspicion when patients complain of seemingly inconsequential neck pain following trauma. Physicians are encouraged to at least consider a lateral cervical spine x-ray to rule out a significant cervical lesion. ★★★

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Esophageal Variceal Sclerotherapy: University of Mississippi Medical Center and Jackson Veterans Administration Medical Center Experience — 1980-1984

SAMUEL C. PACE, M.D., Tupelo Mississippi, and JAMES L. ACHORD, M.D., Jackson, Mississippi

THE MANAGEMENT OF PATIENTS with esophageal variceal bleeding has been controversial, often debated, and frustrating. Graham and Smith in 1981 emphasized the plight of the patient with variceal bleeding.[1] In 85 consecutive patients they found a mortality of 42% at six weeks. Sixty percent of the early deaths and 48% of the late deaths were secondary to bleeding. One-third of the patients rebled within six weeks and one-third of the survivors of rebleeding bled again within three years.

Physicians have taken many approaches in the emergency management of massive hemorrhage from esophageal varices. Balloon tamponade, intravenous or arterial vasopressin, and portacaval shunts are used but with limited effectiveness and unacceptable mortality. For instance, emergency portacaval shunts have been reported to be associated with an operative mortality of 42%.[2] Elective shunts, even though they have an operative mortality of 10%, still have a 20-40% incidence of portal systemic encephalopathy postoperatively.[3]

Therefore it is not difficult to understand the resurgence of endoscopic variceal sclerotherapy, a procedure initially described in 1939.[4] During the past 10 years, numerous papers have been written about sclerotherapy of esophageal varices. This paper reviews our results with this procedure in terms of halting active variceal bleeding, preventing rebleeding, and prolonging survival.

From the Departments of Medicine, University Medical Center and VA Medical Center, Jackson, MS.

Materials and Methods

All patients who were admitted to the University of Mississippi Medical Center and Jackson Veterans Administration Medical Center between January 1980 and December 1984 and who had variceal sclerotherapy were reviewed. The diagnosis of endoscopically proven variceal hemorrhage was defined as (1) active bleeding from varices, (2) blood in the upper GI tract in the presence of varices without any other lesions to explain the bleeding, or (3) known recent UGI bleeding elsewhere manifested by hematemesis or bloody lavage and only the presence of varices at our endoscopy.

Each patient was categorized according to the cause of his or her portal hypertension (see Table 1) and the severity of liver disease as assessed by a modified Child's classification.[5] The first sclerotherapy was the index point for the review.

Intravariceal injection was used with only rare use of the Williams oversheath to aid injection. Five percent sodium morrhuate was used until mid 1983. Sodium tetradeclysulfate, absolute alcohol, and normal saline in equal parts have been used since mid 1983. The average quantity of sclerosant used was 1-2 cc per injection and 8-12 cc per procedure. As a rule, a second sclerotherapy session, when performed, was done during the same admission within one week of the initial sclerosis. Those patients who had chronic sclerotherapy were injected on a monthly schedule until endoscopy revealed obliterated varices.

In an effort to assess our results with sclero-

therapy in stopping active variceal bleeding, the records were analyzed according to the following criteria. Active bleeding was defined as either visible evidence of blood coming from a varix or a fresh clot present on a varix seen at endoscopy. Satisfactory control of bleeding was defined as cessation of bleeding with subsequent discharge of the patient from the hospital or if the patient expired, his/her death was not secondary to uncontrolled bleeding. Unsatisfactory control was defined as persistent bleeding requiring emergency portacaval shunt or the death of the patient either from exsanguination or as a complication of sclerotherapy.

To determine the percentage of patients rebleeding, the number who rebled was divided by the number at risk for rebleeding. Some patients rebled more than once at varying intervals from the initial sclerosis. As patients expired or were referred for shunts or lost to follow-up, they were subtracted from the denominator.

In calculating survival the numerator represents patients surviving and the denominator reflects those patients at risk of dying. Subtraction was made from the numerator and denominator at the appropriate time for those lost to follow-up, referred for shunt, or those who were present in the study group for less than one year.

Results

Patient Classification

Between 1980 and 1984 there were 716 episodes of upper gastrointestinal hemorrhage seen in consultation by the Division of Digestive Diseases. Of these, 174 episodes were due to esophageal varices. A total of 57 patients had sclerotherapy but one patient was excluded from the review because his records were unavailable.

The age range was 13-68 years with the mean age of 49.4 years. Sixty-eight percent were male and 32% female. The disease severity was Child's A in 27% (15/56), Child's B in 34% (19/56), and Child's C in 39% (22/56). The causes of portal hypertension are shown in Table 1 with alcoholic cirrhosis being the cause in 71% (40/56) of the patients.

Control of Active Variceal Hemorrhage

There were 33 admissions (32 patients) in which active bleeding at the time of sclerotherapy was present. Satisfactory control of bleeding was obtained in 23 of 33 admissions (70%). Of the 10 admissions with unsatisfactory control of bleeding, seven died from exsanguination; two died after emergency portacaval shunt (one of these exsanguinated and the other died of cardiopulmonary arrest); and one died from a lethal complication of sclerotherapy (aspirated and developed adult respiratory distress syndrome).

TABLE 1
CAUSES OF PORTAL HYPERTENSION UMC/VA 1980-84

Diagnosis	*Number of Patients*	*Percentage*
Alcoholic cirrhosis	40	71
Cryptogenic cirrhosis	7	12
Portal vein thrombosis	3	5.3
Post viral cirrhosis	2	3.3
Lupoid hepatitis	2	3.3
Budd-Chiari	1	1.7
Cystic fibrosis	1	1.7
Primary biliary cirrhosis	1	1.7
Total	56	100

In the 55 study patients, both those actively bleeding and those not actively bleeding at sclerotherapy, successful control of bleeding was obtained in 52 of 66 admissions (79%). Eleven of the fourteen patients whose bleeding was not controlled died of exsanguination. The cause of death of the three remaining patients is explained above. Ten of the fourteen whose bleeding was not controlled were Child's C, three were Child's B, and one was Child's A.

Prevention of Rebleeding

Thirty-eight of 56 (68%) patients had rebleeding at some time following their first sclerotherapy, some rebleeding more than once. Fifty percent (28/56) of the patients rebled within two weeks of their initial sclerosis (see Figure 1). Three of 27 patients (11%) had rebleeding between six and twelve weeks after sclerotherapy.

Thirty of 56 patients had only one sclerotherapy session. This large number (17 of 30) of single sclerotherapy sessions was influenced significantly by early death (less than 14 days after initial sclerosis) or referral for shunts. Nine patients had five or more separate sclerotherapy sessions with one patient having 12. This patient bled 18 months after her sixth sclerosis and has not bled again following resumption of sclerotherapy.

Obliteration of varices was infrequently obtained by our procedures. In one patient obliteration of varices was noted but this patient bled from a small varix only two weeks later.

Survival

Of the 56 total patients reviewed only 33 could be assessed regarding one year survival because the remaining patients were either referred for shunts, lost to follow-up, or had their initial sclerotherapy at less than one year from the point of the review. The one year survival was 30% (10/33). At one month 63% (31/48) had survived (see Figure 2).

When survival was assessed according to Child's classification the survival curves were as previously reported and best in those with less severe liver disease (see Figure 3). Child's A, B, and C had one year survivals of 60%, 42% and 13% respectively. Those in Child's C had a one month survival of only 32%. To compare, Child's A patients had a one month survival of 91% and Child's B at one month had an 88% survival.

Complications of Sclerotherapy

There were 137 separate sclerotherapy sessions performed on the 56 patients. A total of 29 complications occurred for a complication rate of 21% (29/137).

Fever (10 patients) was the most frequently associated complication followed by transient chest pain in seven patients. Esophageal ulceration occurred in six patients and one patient developed an esophageal stricture. These may be considered minor complications and comprised 83% (24/29) of all the complications.

Major complications occurred in five patients (5/56, 8.9% of patients or 5/137, 3.6% of procedures). Four patients developed pulmonary complications

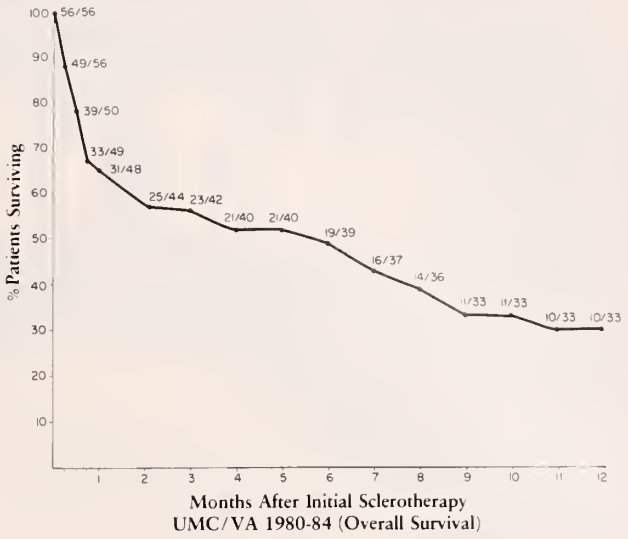


Figure 2

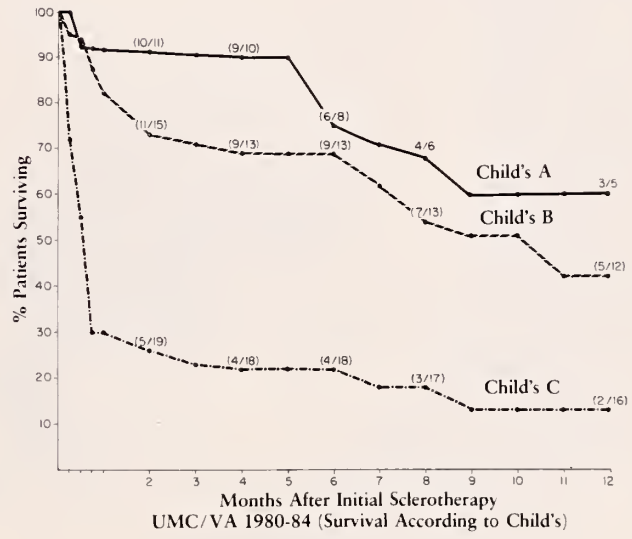


Figure 3

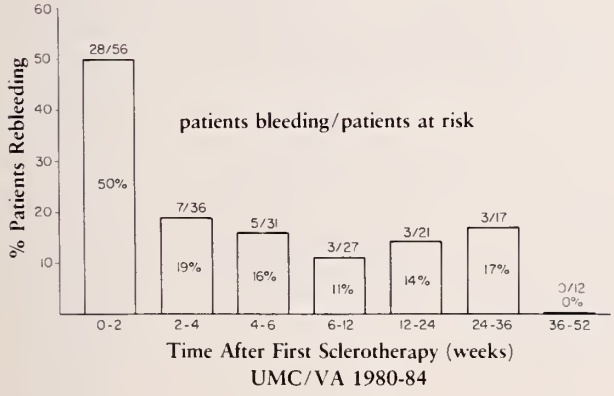


Figure 1

(aspiration pneumonia-1, adult respiratory distress syndrome-1, pleural effusion-2) and one patient had precipitation of brisk variceal bleeding by sclerotherapy. Death resulted from adult respiratory distress syndrome following aspiration during the procedure in one patient. Thus 17% (5/29) of the complications were major with one of 29 complications of sclerotherapy resulting in death. Mortality of the sclerotherapy procedure was therefore 1.7% (one of 56 patients).

Causes of Death

Thirty-two of the 56 patients have expired during the course of the past four years. Liver failure was the most frequent cause of death occurring in 14 patients (four had terminal variceal bleeding). Five patients died cardiopulmonary deaths (ARDS), three patients developed spontaneous bacterial peritonitis and succumbed to sepsis, eight patients died of uncontrolled variceal bleeding, and two patients expired at other hospitals of unknown causes.

Discussion

Sclerotherapy, an old procedure in which interest has recently been revived, has yet to be proven to be the treatment of choice for bleeding esophageal varices. In the past four years, the first truly controlled studies on sclerotherapy have been published and suggest that sclerotherapy is effective in halting active variceal bleeding,[6] preventing rebleeding, and prolonging survival.[7, 8]

The first problem the physician faces in the management of variceal bleeding is stopping the active hemorrhage. Graham and Smith demonstrated the impact active bleeding has on mortality when they found a two day mortality of 50% if there was active bleeding at the time of endoscopy as opposed to 13% if there was no active bleeding. Certainly active hemorrhage at the time of sclerotherapy lessens the chance of successful control of bleeding. Allison's review of studies prior to 1983 revealed that sclerotherapy was successful 79-96% of the time in stopping the active bleeding.[6] However, he noted that "acute variceal hemorrhage" is poorly defined in the literature which sometimes fails to distinguish between active bleeding and temporarily abated hemorrhage. For instance, 15-42% of variceal hemorrhages may stop spontaneously within 24 hours. Nevertheless, sclerotherapy appears to have a definite role in the management of acute variceal bleeding.

In our review successful control of bleeding was achieved in 70% of the cases where there was active bleeding and in 90% when there was no active bleeding at the time of sclerosis. Thus we believe our overall success rate of 79% supports the continued use of sclerotherapy to stop acute variceal bleeding.

The problems in a patient with variceal bleeding do not end with cessation of the initial bleeding. Rebleeding occurs frequently. Fifty percent of our patients rebled within two weeks following their first sclerotherapy but the tendency to bleed again diminished rapidly with only 11% of our patients rebleeding at 6-12 weeks after their index sclerosis.

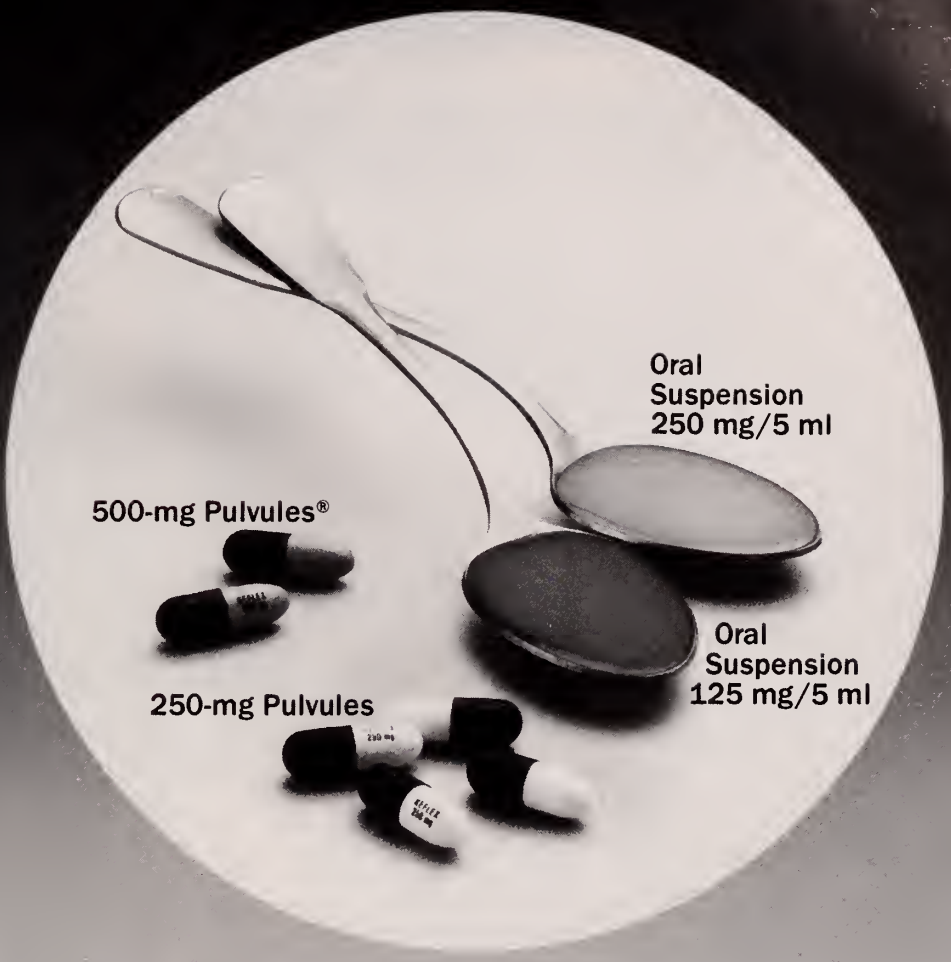
The rebleeding pattern we observed mirrors two controlled studies[7, 8] in which matched patients were assigned randomly to either a medical regimen group or sclerotherapy group. Both studies showed that the marked reduction in rebleeding with sclerotherapy began to occur only after several procedures. The study of MacDougall, et al[7] revealed that 17% of their sclerotherapy group rebled between 3-6 months after initial sclerosis compared to 50% of their medical control group. The Copenhagen Sclerotherapy Project's study (8) revealed that 40 days from the first sclerosis the sclerotherapy group had a rebleed rate of 31% compared to 60% in the control group ($p < .0006$). Despite the success with a reduction of rebleeding with sclerotherapy in the late period (> 40 days from initial sclerosis) there are no controlled studies at present that demonstrate a significant reduction in rebleeding in the early period. It is the control of bleeding in this early period that may hold the key to dramatically improving the survival of the patient with variceal bleeding.

At present conflicting studies exist regarding survival with sclerotherapy. Terblanche's[9] five year prospective study failed to demonstrate prolonged survival with sclerotherapy. The study can be criticized because emergency sclerotherapy was performed on some patients in the control group. On the other hand the Copenhagen Sclerotherapy Project[8] showed improved survival. The mortality rate of the sclerotherapy group, after stratifying for encephalopathy and ascites, was only 63% of the medical group's mortality. MacDougall, et al[7] also demonstrated prolonged survival with sclerotherapy. The one year survival with sclerotherapy was 75% compared to 58% in the medical group ($p = 0.012$).

However, findings of DiMagno, et al[5] in a retrospective review at the Mayo Clinic question the composition of the contro' group in MacDougall's study. They observed that their Child's C alcoholic cirrhotics' survival at one year was 50% compared to 0% survival in Child's C non-alcoholic cirrhosis. In reviewing MacDougall's study they noted that the control group had 20% more non-alcoholic cirrhotics than the sclerotherapy group, possibly contributing to a poorer survival in the control group. Therefore it may be important to match control and sclerotherapy groups not only according to Child's classification but also according to the etiology of their liver disease.

The results of our study reaffirmed that the degree of liver impairment determines survival. Child's A

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and B one year survivals were 60% and 42% respectively, whereas Child's C survival was a dismal 13%. Our overall one year survival in patients receiving sclerotherapy was 30%. To compare, Graham and Smith's[1] one year survival in patients with variceal bleeding without sclerotherapy was also 30%. So our experience with sclerotherapy has not shown improved survival if we take the liberty of comparing with historic controls.

One must be cautious when comparing retrospective uncontrolled studies to prospective controlled studies. Sclerotherapy studies in particular are difficult to compare because they may vary in the urgency of the procedure, nature of the sclerosant, site of injection, and frequency of subsequent injections. To date the only certainty is that sclerotherapy remains unproven to the satisfaction of all. However, recently released prospectively controlled studies are promising and offer what appears to be a viable form of therapy for bleeding esophageal varices. To resort only to standard medical therapy with its unacceptably high incidence of recurrent hemorrhage would seem unwise. To rely exclusively on shunt therapy, though it is presently the most effective means of reducing rebleeding, would seem hasty when sclerotherapy may be as effective in prolonging survival and would be preferable to shunting based on cost effectiveness alone.[10] More prospective controlled studies are underway and it is hoped they will clarify when and if sclerotherapy should be used. Further, there may be a role for prophylactic sclerotherapy in those with varices and no prior bleeding if future studies confirm the recent work by Witzel et al.[11] Until these studies are completed we will continue to use sclerotherapy to halt active variceal bleeding. To prevent rebleeding we will recommend elective surgical shunts for our Child's class A and high B patients. For those low B and Child's C patients or patients with other poor operative risks, chronic sclerotherapy will be suggested.

Summary

Esophageal variceal sclerotherapy, an old procedure recently revived, seems to be increasing in popularity. However, debate remains as to when and how often it should be used. This paper reviews the experiences at the University of Mississippi Medical Center and the Veterans Administration Medical Center in Jackson, Mississippi, in patients with variceal bleeding who had sclerotherapy between 1980 and 1984. Bleeding in 79% of the admissions was successfully controlled. Rebleeding occurred in 50% of the patients within two weeks of their initial sclerotherapy but by 6-12 weeks the rebleeding rate had diminished to 11%. The one year survival was 30%. One death occurred as a complication of the procedure for a mortality rate of 1.7% (1/56). Sclerotherapy appears to be a relatively safe procedure that, when used in conjunction with other management, provides the physician with a means of controlling bleeding from esophageal varices. Its effect on survival remains undetermined. ★★★

2500 North State Street (39216)

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The President Speaking

The Cream Always Rises to the Top

W. JOSEPH H. BURNETT, M.D.
Oxford, Mississippi

Interacting with our AMA delegates and attending the Chicago AMA annual meeting in June continually has reminded me of the expression "the cream always rises to the top." I can't believe I'm old enough to remember when milk was delivered to our back steps every morning near sunrise. Have you ever seen the old glass milk bottles used for home delivery in the old days? By the time it was brought in from the steps and containing fresh whole milk, one could distinctly see the cream separated at the top of the bottle.

The "cream always rises to the top" very appropriately describes the quality of our AMA delegation and their work at AMA on our behalf. Leadership in our state medical association among friends is one thing, but to jump into a national arena and actively represent our small group of physicians requires exceptional leadership abilities. To effectively investigate, debate and vote on concerns of organized medicine from the East coast to the West coast — from North to South — requires intense study and dedication to service. We certainly get both and more from our delegates to AMA. All there recognize that our delegates are informed, prepared and ready to serve. Our small delegation with limited voting capabilities demonstrate their pride to represent Mississippians and effectively insist our voices be heard. As did I, you would proudly stand with them and think to yourself, "Boy! Am I proud of these men, and am I thankful 'the cream always rises to the top.' "

On behalf of all of us, I would like to recognize and thank the "cream" of MSMA for their dedication and outstanding service: Dr. Lamar Weems, Dr. Sidney Graves, Dr. Jimmy Waites, Dr. Ed Hill, Dr. Carl Evers, Dr. Bill Gates, Dr. Gerald Gable, Dr. Mal Morgan, and Dr. Whit Johnson.

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XXXVII, Number 7
JULY 1986

High Tech in Rural Mississippi

I really thought I was somebody — that I had come of age — when I could get my potassium unknown to come out the same as the biochemistry lab's known. But that was way back when I was "smart." Never in my wildest dreams would I have ever imagined serum potassiums to be so easy to do that some lowly (untechnical) person such as I have now could do those same tests accurately and consistently that I in all my brilliance had managed to do only after all those long hours of study and training.

Who would have ever though 30 years ago that in my town of under 1,000 people I would be able to do sophisticated laboratory chemistries and automated hematology right here in my office? Which brings me to the topic of *In-Office Testing*.

Growing numbers of physicians are doing in-office testing with figures ranging to 97% of partnerships and 87% of solo practitioners. This increase is felt to be due partially to the advent of newer and more reasonably priced machinery, combined with an acceptable level of accuracy; reduction in income due to medicare fee freeze; partially due to convenience, particularly in rural areas; and partially due to the fact that accurate in-office testing is just plain good medicine. Not only that but in the current governmental vernacular, it is cost effective.

Apparently the Health Care Financing Administration would very much like to control this area of medicine. So far it neither has the power to do so nor has it sought that control. Sooner or later some guidelines to performance standards will be made. I hope these guidelines will be voluntary, as that may be the only way to avoid another wave of governmental control. The pessimists on the subject feel that the government will ultimately have control perhaps by regulating fees for these services and in that way slow the increased activity in this area of medical practice. The optimists, such as I, see this as an area of extreme assistance to the rural areas of our nation, and believe that governmental intervention will be minimal.

It is hard for me to believe that physicians do not monitor and maintain quality control of their own laboratory tests. Surely it behooves each of us to teach our technicians well and insist on quality control to assure us of reproducible laboratory results that will add to our diagnostic and therapeutic effectiveness.

Under the watchful eyes of the American Medical Association, the American College of Internal Medicine, the College of American Pathologists, and the American Academy of Family Physicians are working on a cooperative approach through the Intersociety Committee on Office Laboratory Assessment to attempt to deal with some of the inherent problems with inter-office testing.

I feel it is necessary for our state to have its own voluntary quality control and proficiency testing for in-office laboratories. This should be under the auspices of the state medical association or a joint venture as mentioned above. This is for our benefit as well as our patients' benefit and would incorporate a section designed to assist the practicing physician in problems with his own laboratory. At the present time the only ones we can turn to with our problems are those who sell us the equipment. "Easy enough for your receptionist to use" may be a good selling point but may speak poorly for the reliability of the test results. Yes, proficiency testing is important. We must make certain that the time and expense of such testing does not overshadow the benefits of the tests.

Few areas of medicine are undergoing such dramatic change at the present time as in-office laboratory examinations, so let us get together and make it a good, effective, and lasting experience.

JOSEPH E. JOHNSTON, M.D.
Associate Editor

Counsel to Authors

THE JOURNAL welcomes manuscripts which should be submitted to the Editors at 735 Riverside Drive, Jackson, MS 39216, in original and at least one duplicate copy. They must be typewritten double spaced on 8½ by 11-inch white paper. **Brief manuscripts (about 2,500 words or 8 pages) will be given preference over longer articles.**

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All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus*, volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made.

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Reprints may be obtained at cost plus shipping charges from the association and **should be ordered prior to publication.** The JOURNAL reserves the right to decline any manuscript. Authors should avoid placing subheads in the text, and the Editors reserve the prerogative of writing and inserting subheads according to JOURNAL style. — *The Editors.*

In addition, in view of *The Copyright Revision Act of 1976*, effective Jan. 1, 1978, transmittal letters to the editor should contain the following language: "In consideration of the Mississippi State Medical Association's taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the MSMA in the event that such work is published by the MSMA." We regret that transmittal letters not containing the foregoing language signed by *all* authors of the submission will necessitate delay in review of the manuscript. — *The Editors.*

Dr. Burnett Is Inaugurated, Dr. Weems Named President-Elect

Dr. W. Joseph Burnett of Oxford was inaugurated 1986-87 president of the MSMA at the closing meeting of the 118th Annual Session held in Biloxi in June. He succeeds Dr. Ralph L. Brock of McComb. Dr. W. Lamar Weems of Jackson was named president-elect.

The new MSMA president is a native of Charleston and has been in the practice of otolaryngology in Oxford since 1974. He previously served as chairman of the MSMA Board of Trustees.

Dr. Weems, the new president-elect, also was re-elected as AMA delegate, a post he has held since 1979.

More than 800 registered for the five-day session, which featured a full program of scientific, business and fellowship activities.

Among special guests was Dr. Harrison L. Rogers, president of the AMA, who addressed the House of Delegates. He emphasized the importance of a positive attitude toward the future of medicine, and he described for delegates the actions the AMA is taking to effectively represent the physicians of the country and to serve as advocates for their patients.

The importance of a positive attitude was also the theme of another guest speaker, Jerry Clower, who entertained at the annual MSMA/MSMA Auxiliary membership banquet.

In addition to electing new officers, the House of Delegates took action on numerous reports and resolutions concerning health care in Mississippi. A summary of House actions appears on pages 197 and 198 of this issue.



Dr. W. Joseph Burnett of Oxford, center, was inaugurated president of the association during the 118th Annual Session. With him, at left and right, are Dr. Ralph L. Brock of McComb, immediate past president, and Dr. W. Lamar Weems of Jackson, president-elect.



MSMA board chairman Dr. Roy D. Duncan, left, administers the oath of office to Dr. Burnett. He is assisted by MSMA executive director Charles Mathews.



Dr. Burnett receives the president's pin from Dr. Brock, immediate past president.



The new MSMA president poses with his family. Mrs. Burnett (Martha) is at far right. From left are their daughters and son, Kathryn, J., Margaret and Elizabeth.

Board of Trustees Elects Officers

Dr. David R. Steckler of Natchez was elected chairman of MSMA's Board of Trustees during the board's meeting June 8 in Biloxi. Dr. J. Ed Hill of Hollandale was named vice chairman and Dr. David M. Owen of Hattiesburg was elected secretary.

Other members of the board are: Drs. Martin H. McMullan of Jackson, John Paul Lee of Forest, Lee H. Rogers of Tupelo, Stanley Hartness of Kosciusko, Stanley Wade of Meridian and Roy Duncan of Pascagoula.

Elections Highlight House of Delegates Sessions

Delegates to the 118th Annual Session, casting ballots to fill vacancies in MSMA offices, named Dr. W. Lamar Weems of Jackson as the 1986-87 president-elect. Dr. Weems also was re-elected as delegate to the AMA.

As a result of the elections, three new faces will be seen at MSMA Board of Trustees meetings: Drs. D. Stanley Hartness of Kosciusko was named trustee from District 2; John Paul Lee of Forest was named trustee from District 4; and Stanley Wade was elected to represent District 5 on the Board.

Dr. Don Q. Mitchell was elected secretary-treasurer and Dr. Mal G. Morgan of Natchez was elected vice-president. Dr. Morgan also was named alternate delegate to the AMA.

In addition to Dr. Weems and Dr. Morgan, other physicians elected to fill AMA delegate posts include: Drs. Sidney Graves of Natchez, James Waites of Laurel, and Carl Evers of Jackson, delegates. Elected as alternate delegates were: Drs. Elmer Nix of Jackson, Joe Covington of Meridian, and Gerald P. Gable of Hattiesburg.

Dr. Myron W. Lockey of Jackson was re-elected as editor of the JOURNAL MSMA, and Dr. A. A. Derrick was re-named associate editor.

Elected to various council posts were: Drs. David M. Owen of Hattiesburg and Max Pharr of Jackson, Council on Budget and Finance; Drs. Mack Gorton of Belzoni and Frank Wilburn of Tupelo, Judicial Council; Drs. Matthew Page of Greenville, L. C. Henson of Kilmichael and William T. Oakes of Amory, Council on Legislation; Drs. Eric McVey, III of Jackson, Council on Medical Education; Drs. Joel G. Payne of Jackson and T. Keith Everett of Meridian, Council on Medical Service; and Drs. Stanley Hartness of Kosciusko and James Cooper of Tupelo, Council on Public Information.



Dr. Arthur A. Derrick, a past president of MSMA, presents Dr. Brock with the James Grant Thompson Memorial Past President's Pin.



Dr. C. Rod Jenkins of Laurel presented the report of the Reference Committee on Rules and Order of Business.



Dr. and Mrs. Harrison L. Rogers, left, pose with Dr. and Mrs. Ralph Brock during the annual President's Reception. Dr. Rogers, president of the AMA, was a special guest during the 118th Annual Session.



Entertainer Jerry Clower talks with Mrs. Brock during the annual membership banquet.



Jerry Clower tells MSMA and MSMA Auxiliary members, "I Love Y'all!"

Thanks to Our Exhibitors

The following companies and organizations participated in the Technical Exhibit during MSMA's 118th Annual Session in Biloxi:

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Bedsole Surgical Supply
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Janssen Pharmaceutica
Key Pharmaceuticals, Inc.
Knoll Pharmaceuticals
Lanier Business Products
McNeil Pharmaceuticals
Mead Johnson Nutritional Division
Medical Assurance Co. of Mississippi
Medical Pathology Laboratory, Ltd.
Merck Sharp & Dohme
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Miss. Foundation for Medical Care, Inc.
Miss. Methodist Rehabilitation Center
Miss. Neuro-Diagnostic Lab., Inc.
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Travelers Insurance-Medicare
U. S. Air Force
U. S. Army Professional Support Agency
Unifirst Bank for Savings
Weight Watchers in Greater Miss.



Members of the House of Delegates prepare to mark ballots.



118th Annual Session, June 4-8, 1986

HOUSE OF DELEGATES HANDLES BUSY AGENDA

The House of Delegates of the Mississippi State Medical Association handled a busy agenda of relatively non-controversial reports and resolutions at the 118th Annual Session of the association in Biloxi. It was the first time the annual session had been held in the month of June.

The House of Delegates took these major actions:

- Approved plans to fund a new office building through MSMA Services, Inc. at a cost of $2.8 million.
- Endorsed a requirement for health insurors to place a statement on beneficiaries' cards to inform patients and physicians if a certification or preauthorization requirement exists as a condition of payment.
- Voted to have MSMA and its component societies share the expense of sending a component society representative to each annual AMA Leadership Conference.
- Urged each MSMA member to become aware of proposed cuts in federal health funds and to contact the Mississippi congressional delegation in this regard.
- Urged improved communication between Mississippi hospitals and their medical staffs on the socioeconomic environment of health care in the hospital.
- Urged each MSMA member to become familiar with the report of the Special Legislative Study Committee on Indigent Care.
- Commended Mr. Bill Simmons, Director of the Mississippi Medicaid Commission, for his effective administration of the program under increasing adverse circumstances.
- Directed that a study be done to determine the feasibility of requiring train cars to have reflectors or be painted with reflective paint.
- Support passage of a Clean Indoor Air Act and efforts to increase public awareness of the dangers associated with the use of tobacco products.
- Reaffirmed association support for physician representation on hospital governing boards.
- Directed that efforts be undertaken to promote a reduction in deaths and injuries related to firearms.
- Commended and supported efforts of a task force recently appointed by the State Superintendent of Education to propose a health curriculum for Mississippi's public schools.
- Restated support for enactment of a compulsory seat belt law.
- Directed that a study be conducted to determine the feasibility of requiring all employers in the state to carry health insurance on their employees.
- Supported legislation to require a health insurance pool for high-risk individuals.
- Urged that practicing physicians be used in peer review activities and have similar training to the physician under review.
- Receive a report that the association had a net increase in membership during the first year of unified membership and reaffirmed support for unified membership.
- Presented the MSMA Community Service Award to Dr. Robert L. Donald of Pascagoula.

● Presented checks for $20,136.74 and $3,715.00 to the University of Mississippi medical school. The gifts represent AMA-ERF contributions by Mississippi physicians and their spouses.

Serving on Reference Committees of the House were:

Reference Committee on Rules and Order of Business

Charles R. Jenkins, M.D., Chairman
Myron W. Lockey, M.D.

Reference Committee on Reports of Officers, Board of Trustees and Councils

William C. Gates, M.D., Chairman
Hugh A. Gamble, II, M.D.
E. J. Price, Jr., M.D.
Arthur D. Cromartie, M.D.
Orin F. Guidry, M.D.

Reference Committee on Constitution and Bylaws

Frederick E. Tatum, M.D., Chairman
Max L. Pharr, M.D.
Eric E. Lindstrom

Credentials Committee

J. Elmer Nix, M.D., Chairman
Whitman B. Johnson, M.D.
Andrew K. Martinolich, M.D.

Nominating Committee

Arthur A. Derrick, M.D., Chairman
L. Stacy Davidson, M.D.
William T. Oakes, M.D.
William F. Sistrunk, M.D.
Kent Allen Darsey, M.D.
Gerald P. Gable, M.D.
Mal G. Morgan, M.D.
J. Berlyn Edwards, M.D.

119th Annual Session
June 3-7, 1987
Biloxi, MS



Dr. John Morgan of McComb, chairman of the Hospital Medical Staff Section.



Dr. Fred Tatum of Hattiesburg, chairman of the Reference Committee on Constitution and Bylaws.



Dr. Bill Gates of Columbus, chairman of the Reference Committee on Reports of Officers, Board of Trustees and Councils.



Delegates listen to instructions from the Speaker of the House.



UMC vice chancellor for health affairs and school of medicine dean Dr. Norman A. Nelson, second from right, received from Dr. Brock checks for $20,136.74 and $3,715. The gifts represented AMA-ERF contributions to the school from Mississippi physicians and spouses. Assisting in the presentation were Dr. James C. Waites, second from left, president of the University of Mississippi Medical Alumni Chapter, and Mrs. David Owen (Sara Ann), AMA-ERF chairman for the MSMA Auxiliary.



Dr. Bob Donald of Pascagoula, right, received the MSMA Community Service Award from Dr. Brock.



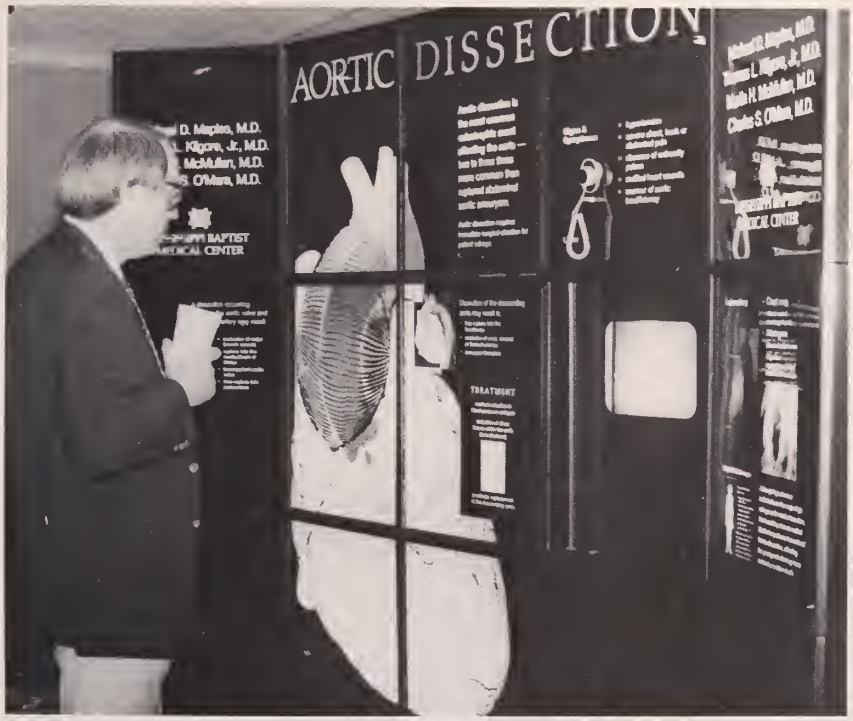
Dr. G. C. Sutherland, medical director of Medical Assurance Company of Mississippi, presented the Robert S. Caldwell Memorial Award to Dr. Bobby L. Graham of Meridian.



Dr. Brock, center, hosted the 50-year-club luncheon. From left are Drs. J. Gordon Dees, Guy Vise, Alex Baines, and Eldon Bolton.



Rick Cornett of PHP described operating plans for MSMA's HMO/IPA.



"Aortic Dissection," an exhibit by Drs. Maples, Kilgore, McMullan and O'Mara, won the Aesculapius Award for excellence of presentation.



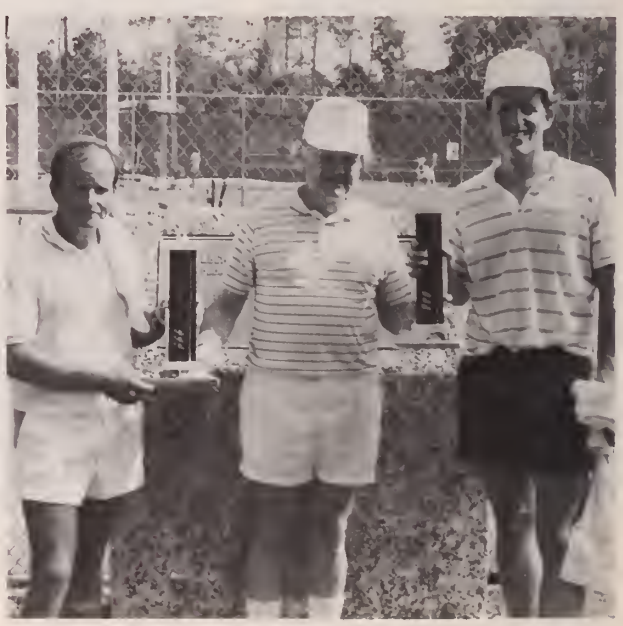
At right, Dr. Lamar Weems addressed the House after he was named MSMA president-elect.



1986-87 MSMA Auxiliary officers were installed at the Annual Session. From left are Mrs. D. P. Smith, first vice-president; Mrs. Ted Blanton, parliamentarian; Mrs Thomas J. McDonald, second vice-president; Mrs. Joe Herrington, president-elect; Mrs. George Wilkerson, fourth vice-president; Mrs. Dale Russwurm, treasurer; Mrs. James C. Waites, president; and Mrs. Ben Martin, immediate past president.



Winners of the women's doubles competition, Dr. Lorg Giles and Marianne Spence, receive their trophies from Dr. John Fair Lucas, Jr., tournament chairman.



Dr. William Seidensticker, left and Dr. Don Gaddy, right, winners of men's doubles competition, receive their trophies from Dr. Lucas.



Lindsey Morgan, daughter of Dr. and Mrs. Mal Morgan of Natchez, was a winner in the fishing rodeo.



Steve Parvin, Jr., son of Dr. and Mrs. Steve Parvin of Starkville, displays his prize-winning bonita.

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Medico-Legal Brief

Accident Victim's Estate Can Sue Physician of Driver for Malpractice

The estate of an automobile accident victim could maintain a medical malpractice action against a physician who treated the driver of the car who caused the accident, a Michigan appellate court ruled.

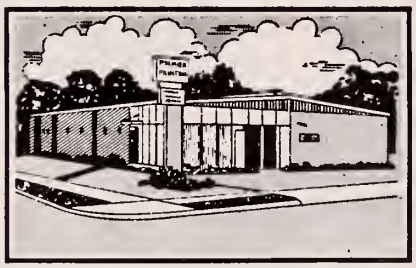
The patient was driving an automobile owned by the physician when it crossed the center line and collided with an automobile operated by the victim. The victim died of injuries. Prior to the accident, the physician had been treating the driver of his car and had prescribed medication for her. On the evening prior to the accident, he allegedly injected her with an unknown substance. The estate of the victim filed a wrongful death action against the driver of the physician's car and later moved to amend the complaint to add a medical malpractice count against the physician. A trial court denied permission to add the medical malpractice claim, and the estate appealed.

Reversing the decision, the appellate court said that the physician owed a duty to the innocent driver who was killed in the accident with his patient. The court said liability was properly imposed where a physician's malpractice was the proximate cause of injuries and where the physician himself was in the best position to prevent the harm. The court said that the physician had a special relationship with his patient because he could have determined that his patient posed a serious threat of danger to other persons. — *Welke v. Kuzilla,* 375 N.W.2d 403 (Mich.Ct. of App., July 15, 1985)

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PERSONALS

GEORGE E. ABRAHAM, II of Vicksburg spoke at a recent seminar on allergies in Vicksburg.

JAMES ACHORD of UMC was the American College of Physicians' representative to the Council on Subspecialty Societies in San Francisco.

ORLANDO ANDY of UMC served as president-elect at the organizational meeting of the Southern EEG Society in New Orleans and presented a paper at the Society of Biological Psychiatry meeting in Washington, DC.

LODOVICO BALDUCCI of UMC presented a paper at the American Society of Clinical Oncology in Los Angeles.

GENE R. BARRETT of Jackson lectured on knee ligament repairs at the American Academy of Orthopaedic Surgeons in New Orleans and at the Mid-America Orthopaedic Association meeting in Orlando, Florida.

G. WILLIAM BATES of UMC was a program participant at a meeting of the American College of Obstetricians and Gynecologists in New Orleans and was guest lecturer at the National Symposium on Prolactin Disorders in Marco Island, Florida.

JOHN R. BISE of Jackson conducted a round table discussion at the American College of Obstetricians and Gynecologists Clinical Meeting in New Orleans and participated in the American Society of Laser Medicine and Surgery annual meeting in Boston.

JOHN D. BURK of Tupelo presided as president of the American Diabetes Association's annual meeting in Jackson.

GEORGE BUSH of Laurel has been recertified by the American Academy of Family Physicians.

MARTIN DALTON of UMC spoke at a meeting of the Texas Medical Association in Dallas.

JOHN DRAKE of Ocean Springs was speaker at a sports medicine symposium in Pascagoula.

GEORGE H. ELLIS announces the opening of Rankin Family Health Clinic at 3560 Highway 80 East in Pearl.

CARL EVERS of UMC was a program participant in the AAMC Southern Regional Group on Student Affairs meeting in San Antonio, Texas.

ELMO P. GABBERT of Meadville recently was named to the Board of Directors of the University of Mississippi Medical Alumni Chapter.

RICHARD GEORGE of Columbus has been recertified by the American Academy of Family Physicians.

JAMES O. GORDON, JR. of Tupelo spoke at the annual meeting of the Mississippi Academy of Family Practice in Biloxi.

CHARLES GUESS of Jackson appeared on WAPT's "Health Matters" program.

JAMES HARDY of UMC recently was initiated into the University of Alabama Chapter of Phi Beta Kappa in Tuscaloosa.

WOOD HIATT of UMC was host and moderator for the annual Mississippi Conference on Child Abuse in Jackson.

JENNIFER O. HICKS announces the opening of her practice of obstetrics and gynecology at 1717 Cherry Street in Vicksburg.

ROBERT L. HOWLAND of Columbus has been elected a member of the board of Blue Cross and Blue Shield of Mississippi, Inc.

HERBERT LANGFORD of UMC made a presentation at the National Heart, Lung and Blood Institute recruitment workshop in Bethesda, Maryland.

CONNIE MCCAA of UMC presented a poster session at the meeting of the Association for Research in Vision and Ophthalmology in Sarasota, Florida.

JOHN MCCLOSKEY of Pascagoula spoke on neurological injuries at a sports medicine seminar in Pascagoula.

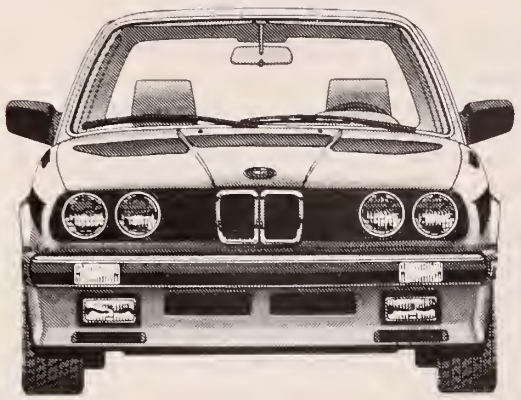
ROBERT MIDDLETON of Biloxi has been recertified by the American Academy of Family Physicians.

FRANCIS MORRISON of UMC was in the People's Republic of China where he served as consultant and gave lectures on blood transfusion to branches of the Chinese Medical Association in Beijing, Tianjin, Nanjing, Wuxi, and Shanghai.

JOHN MORRISON of UMC presented grand rounds at the University of Tennessee in Knoxville, and was a program participant at a meeting of the American College of Obstetricians and Gynecologists in New Orleans.

WILLIAM NICHOLAS of UMC spoke at the annual meeting of the American Diabetes Association in Jackson.

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PERSONALS/Continued

HOWARD NICHOLS of UMC was an examiner for the American Board of Pediatrics in Washington, DC.

CHARLES O'MARA of Jackson presented a paper at the recent meeting of the Southeastern Surgical Congress in New Orleans.

SHANTI PANDEY of Fayette has been recertified by the American Academy of Family Physicians.

JOHN PENDERGRASS of Hattiesburg spoke on eye diseases at a "Forever Young" class at Methodist Hospital.

LAWRENCE RUSSO of Pascagoula spoke at a recent community health education series sponsored by Singing River Hospital.

MAX TAYLOR of Tupelo presented an abstract on nosocomial pneumonia at the Centers for Disease Control, National Nosocomial Infection Survey Conference in Atlanta.

TATE THIGPEN of UMC presented a paper at the American Society of Clinical Oncology in Los Angeles.

DENNIS THOMAS of Pascagoula spoke at a community health education series sponsored by Singing River Hospital.

RALPH VANCE of UMC presented a paper at a meeting of the American Society of Clinical Oncology in Los Angeles.

RICHARD VISE of Meridian recently was elected as the Mississippi representative to the board of directors of the Southeastern Section of the American Urological Association at its meeting in Puerto Rico.

TERRY WESTBROOK and STEVEN C. WILLIAMS, both of McComb, recently spoke at Southwest Mississippi Junior College, at a session for nursing students.

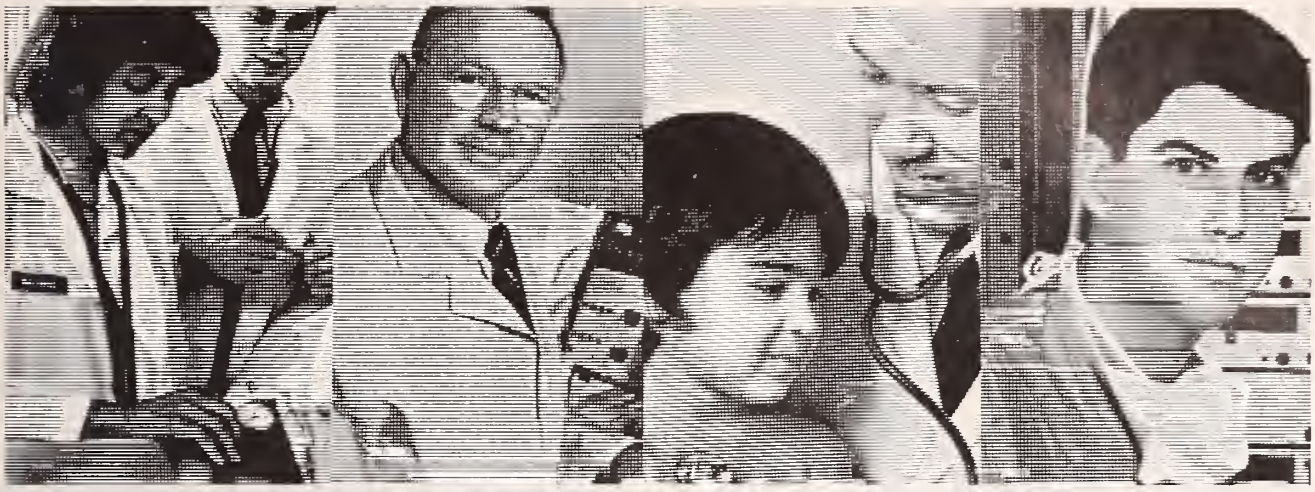
CHRIS E. WIGGINS of Ocean Springs spoke at a sports medicine symposium and a community health education seminar in Pascagoula.

WINFRED WISER of UMC participated on the Accreditation Appeals Board in Chicago.

NEW ADDRESS

MSMA headquarters has moved to 236 East Capitol Street (third floor, Great Southern National Bank). Mailing address continues to be P.O. Box 5229, Jackson, MS 39216.

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PHYSICIANS NEEDED

Physicians (especially specialists such as ophthalmologists, pediatricians, orthopedists, neurologists, etc.) interested in performing consultative evaluations (according to Social Security guidelines) should contact the Medical Relations Office. WATS 1-800-962-2230; Jackson, 922-6811; extensions 2275, 2276, 2249 or 2190.

The Mississippi Disability Determination Services now has a program available for medical society meetings and hospital staff meetings. The purpose of this program is to explain the Social Security Disability program, the medical documentation requirements, and how the disability determination process works. Any group interested in this presentation should also contact the Medical Relations Office.

EMERGENCY PHYSICIANS WANTED. Part-time and full-time positions. Columbus, MS. Call (601) 328-8385.

EMERGENCY ROOM physician needed to staff recently expanded emergency room coverage. Salary negotiable. Small town. 44-bed hospital approved for federal programs, located in central Mississippi. Contact Paul W. Strode, Box 428, Forest, MS 39074.

EMERGENCY MEDICINE and FAMILY MEDICINE positions available. Full-time positions available in hospital emergency departments and clinics. Prefer residency-trained or experienced physicians. Career opportunities available in central and south Mississippi. Attractive salary and benefit package. MEA, P.A. is a physician-owned and managed medical group committed to the financial security and personal development of each physician member. For information, contact: Sheila M. Lunceford; P.O. Box 12917, Jackson, MS 39236-2917; or call (601) 366-6503.

FAMILY MEDICINE positions available. Board certified or board eligible family physicians needed by largest multi-specialty group practice in state. Located 75 miles north of Mississippi Gulf Coast. Contact T. G. Thornton, Administrator, Hattiesburg Clinic, 415 South 287th Ave., Hattiesburg, MS 39401; (601) 268-5601.

MISSISSIPPI GULF COAST — Emergency Physician position available in Level II, medium volume ER. Two years experience or primary care specialty, ACLS required. Local ambulance service has ALS capability. Participation in EMS expected. Good recreational area, on the water, 65 miles east of New Orleans by Interstate. Contact David Sawyer, M.D., Box 209, Pass Christian, MS 39571; (601)865-1188 or (601)452-7581.

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RADIOLOGIST seeks private or hospital based clinical practice preferably emphasizing nuclear medicine. Graduate of U. of South Alabama Medical School, 1981. Contact Dr. H. T. Williams, 1663 Veteran Ave., Apt. 306, Los Angeles, CA 90024.

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Index to Advertisers

American Medical International **10B**

Bienville Center **4**

Canton Exchange Bank 203
Curtis 1000 Information Systems **6**

Disability Determination Services 208

Harreld Chevrolet-Oldsmobile 204

Janssen Pharmaceutica 182

Knoll Pharmaceutical 186B, 186C, 186D

Eli Lilly and Company 186A

Medical Assurance Co. of Miss. **10**
MSMA Benefit Plan and Trust ..... **second cover**

Premier Printing 204

Roche Laboratories ..... **third, fourth covers**

United Realty 203
The Upjohn Company **10A**
U. S. Air Force **7**
U. S. Army 207

Harry Vickery 206

Jon Wimbish **12**

Thomas Yates & Co. **8**



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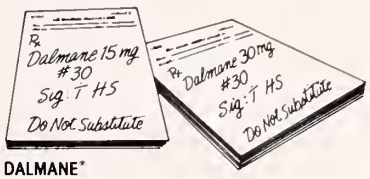
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References: **1.** Koles J, *et al Clin Pharmacol Ther 12* 691-697, Jul-Aug 1971. **2.** Koles A, *et al Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Koles A, *et al. Clin Pharmacol Ther 19* 576-583, May 1976. **4.** Koles A, *et al. Clin Pharmacol Ther 32* 781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR. *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Dement WC, *et al: Behav Med*, pp 25-31, Oct 1978. **7.** Koles A, Koles JD: *J Clin Psychopharmacol 3* 140-150, Apr 1983. **8.** Tennont FS, *et al.* Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984. **9.** Greenblott DJ, Allen MD, Shoder RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977.



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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms rarely reported, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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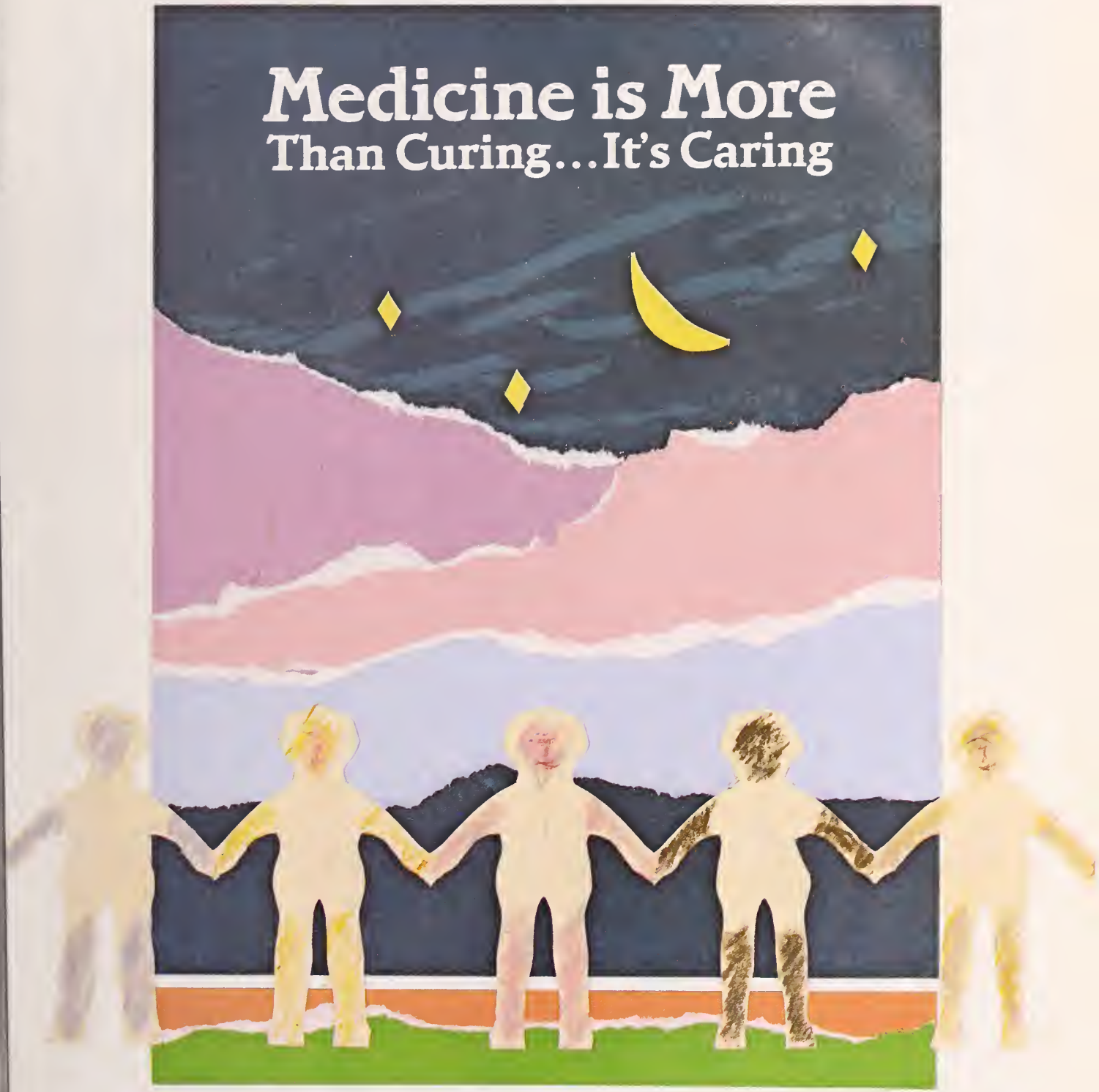
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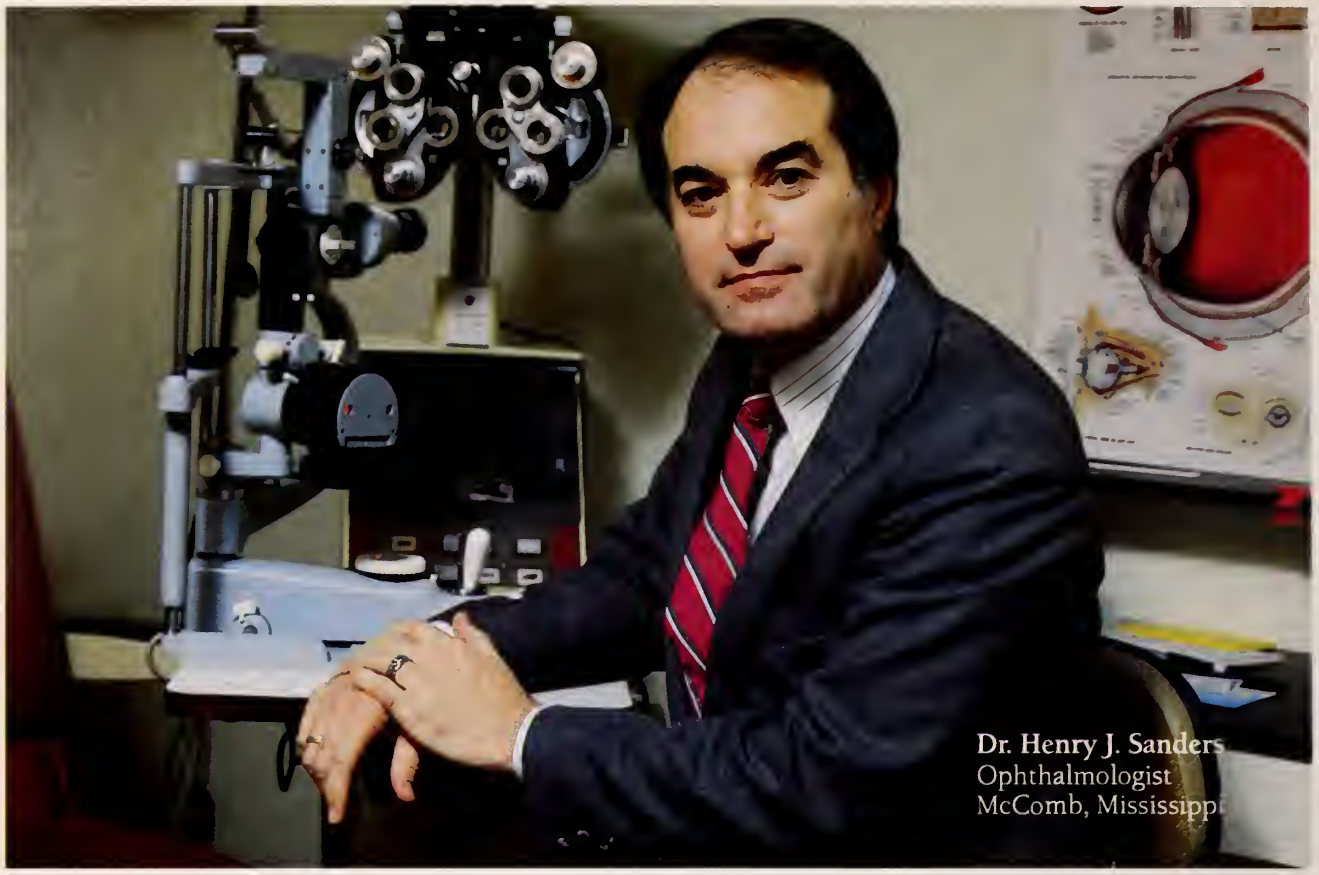
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AUGUST 1986, VOLUME XXVII, NUMBER 8

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The Journal of the Mississippi State Medical Association is owned and published monthly by the Mississippi State Medical Association, founded 1856, at P.O. Box 5229, Jackson, Mississippi 39216. Subscription rate, $25.00 per annum; $35.00 per annum for foreign subscriptions; $2.25 per copy, as available. Advertising rates furnished on request. Printed by The Ovid Bell Press, Inc., Fulton, Missouri. Second-class postage paid at Jackson, Mississippi, and at additional mailing offices. POSTMASTER: Send address changes to Mississippi State Medical Association, P.O. Box 5229, Jackson, Mississippi 39216.

CONTENTS

ORIGINAL PAPERS

Epiglottitis in a Community Hospital — **209** John D. Coffey, Jr., M.D.

Adventitial Cystic Disease of the Popliteal Artery: Case Report — **215** James L. Burkhalter, M.D. and John J. Connors, III, M.D.

EDITORIAL

"Baby Doe" Decision Clarifies Responsibility in Treatment Decisions — **221** Myron W. Lockey, M.D.

THIS MONTH

Where We've Been— Where We're Going — **220** The President Speaking

Withholding or Withdrawing Life Prolonging Medical Treatment — **221** Medico-Legal Brief

222 Medical Organization
227 Personals
229 New Members
231 Deaths

Cover design by Bill Tyler of Jackson. "Medicine is more than just curing . . . it's caring" is the theme of MSMA's Marketing/Communications Kit. It's also a theme that is reiterated in this month's president page article by Dr. Burnett — "Where We've Been — Where We're Going."

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NEWSLETTER

August 1986

Dear Doctor:

Tort reform has been passed in at least 23 states this year, with 18 of those enacting modifications of tort law for all civil actions, rather than just medical liability.

> The adoption of caps on non-economic damages was significant in some areas. At least 13 states passed caps, with seven of those making the law applicable to all civil cases. Caps ranged from a low of $225,000 (Michigan) to $1 million in West Virginia. New requirements on insurance companies were adopted in 19 states, and elimination or modification of joint and several liability occurred in eight states.

The American Hospital Association has undertaken an advertising campaign ("The Cost of Compassion") addressing the problem of medical indigence. With one of every eight Americans having inadequate or no health insurance, the campaign seeks to raise public awareness of the problem and to explain the difficulties hospitals face with uncompensated care (estimated at $6.9 billion a year.) According to the AHA, 33 million Americans currently have neither private nor public health insurance, and of those 65% are working adults or their dependents. The ads are scheduled to appear more frequently in September and October, just before November elections. Many of the ads provide a ballot for consumers to use in expressing opinions to lawmakers.

"Let's show our patients what we've always known: medicine is more than just curing -- it's caring." That's the theme of a new Marketing/Communications Kit prepared by the MSMA Council on Public Information. The kits contain a variety of materials, including information on improving the physician/patient relationship through better communication, suggestions for marketing a practice by matching your services with patient needs, and brochures for your patients on health care costs and changes in the health care system. To obtain your kit, call the MSMA headquarters office or mail the order form enclosed with last month's "Blue Sheet."

Sincerely,

Patsy Silver
Managing Editor



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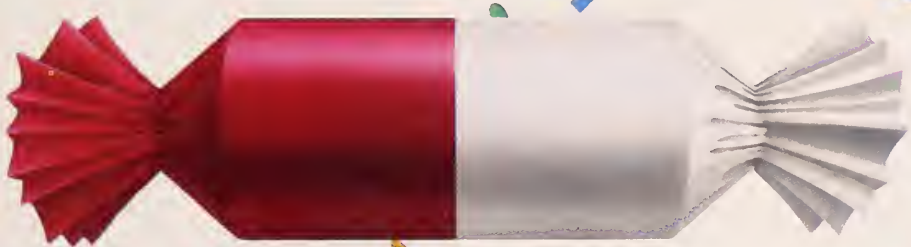
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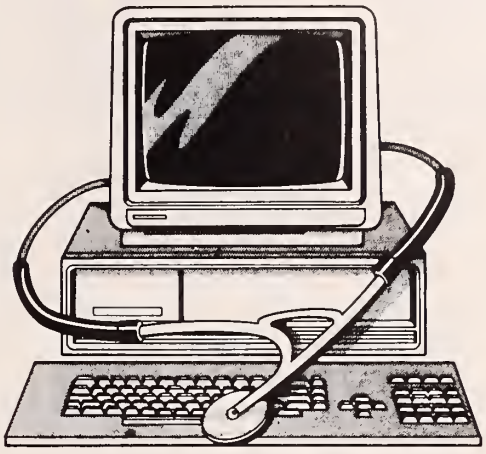
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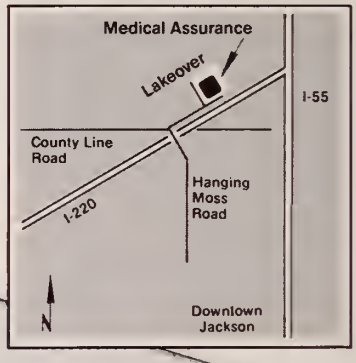
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DATELINE

Ruling Supports Cigaret Ad Ban

Washington, DC - A recent Supreme Court ruling supports AMA arguments that a ban on cigaret advertising is constitutional. The AMA adopted a resolution calling for such a ban at its December Interim Meeting. The court's ruling applies to a Puerto Rico ban on gambling advertisements, and declares that the ban does not violate the First Amendment protections for commercial speech.

Management Plan For MSMA's HMO/IPA

Jackson, MS - A management plan for MSMA's HMO/IPA is nearing completion, after two months of research by staff of Physicians Health Plan (PHP) of Ohio. PHP staff have gathered data, attended medical society meetings, and are now completing a fee survey. Meetings have been held with employers to determine the current benefit market. The proposed management plan is set for completion early next month.

Pap Smears Advised For Elderly Women

Chicago, IL - A study in the July 17 JAMA encourages primary care physicians in out-patient settings to use Pap smears for early detection of cervical cancer in postmenopausal women. The report calls on doctors in non-gynecological primary care settings to screen even asympto-matic women 65 years of age and older. The authors note that 4,000 of the 16,000 annual cases of cervical cancer occur in women over 65.

Medicaid Increases Child Visit Fees

Jackson, MS - In an effort to increase parti-cipation by physicians, the Mississippi Medi-caid program has increased fees paid for services provided to its largest recipient group. Effective last month, child health care (for children under six) will include the following new services and fees: new patient ($25.00) and follow-up evaluation ($18.00). Journal MSMA (June) included an article on physician participation in Medicaid.

AMA Will Offer Patient Billing System

Chicago, IL - The AMA will offer an electronic claims billing system to all members beginning next month. The user friendly system will consist of a telephone mini-computer furnished free to each participating physicians's office. Claims will be submitted via the system to any third party payor in the country, and direct patient-credit card billing will also be provided. Cost will be 55¢ per claim.

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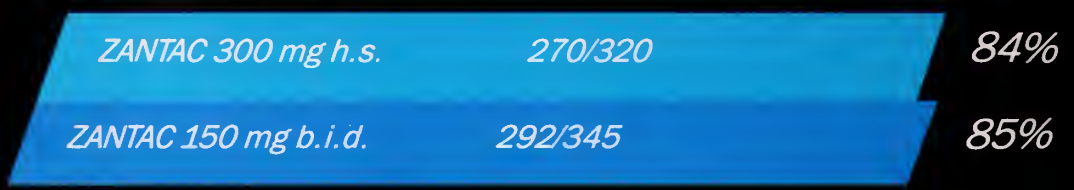
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Controls nocturnal acid to relieve pain and heal duodenal ulcers

Heals active duodenal ulcers after 4 weeks in most patients*[1]



In well-controlled, double-blind, multicenter trials, ZANTAC 300 mg h.s. healed active duodenal ulcers in 84% of patients after 4 weeks. After 8 weeks, healing rates may be higher with ZANTAC 150 mg b.i.d. (92%) than with ZANTAC 300 mg h.s. (87%).

Relieves pain and other symptoms as effectively as ZANTAC 150 mg b.i.d.[1]

Zantac® 300

ranitidine HCl/Glaxo 300 mg tablets

Once-daily dosing may enhance compliance in patients for whom dosing convenience is important

Side-effects profile comparable to ZANTAC 150 mg b.i.d.[1-3]

Headache—sometimes severe—has been reported. Rare effects on the CNS, cardiovascular, GI, hepatic, and integumental systems have been observed, as well as rare cases of hypersensitivity reactions. See ADVERSE REACTIONS section of Brief Summary of Product Information before prescribing.

No significant interference with the hepatic cytochrome P-450 enzyme system at recommended doses

ZANTAC 300 mg h.s. had no significant drug interactions with theophylline or warfarin. The bioavailability of certain medications whose absorption is dependent on a low gastric pH may be altered when ZANTAC or other medications which decrease gastric acidity are administered.



*It is not known exactly how much acid inhibition is needed to heal ulcers.

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See next page for references and Brief Summary of Product Information.

IN ACTIVE DUODENAL ULCERS

Once-a-night h.s. therapy controls acid rain

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ranitidine HCl/Glaxo 300 mg tablets

References: 1. Data available on request, Glaxo Inc. 2. Ireland A, Colin-Jones DG, Gear P, et al: Ranitidine 150 mg twice daily vs 300 mg nightly in treatment of duodenal ulcers. *Lancet* 1984;2:274-275. 3. Colin-Jones DG, Ireland A, Gear P, et al: Reducing overnight secretion of acid to heal duodenal ulcers. *Am J Med* 1984; 77 (suppl 5B):116-122.

ZANTAC® 150 Tablets
(ranitidine hydrochloride)
ZANTAC® 300 Tablets
(ranitidine hydrochloride)

BRIEF SUMMARY OF PRODUCT INFORMATION

INDICATIONS AND USAGE: ZANTAC® is indicated in:
1. Short-term treatment of active duodenal ulcer. Most patients heal within four weeks. Studies available to date have not assessed the safety of ranitidine in uncomplicated duodenal ulcer for periods of more than eight weeks.
2. Maintenance therapy for duodenal ulcer patients at reduced dosage after healing of acute ulcers. No placebo-controlled comparative studies have been carried out for periods of longer than one year.
3. The treatment of pathological hypersecretory conditions (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of active, benign gastric ulcer. Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated. Studies available to date have not assessed the safety of ranitidine in uncomplicated, benign gastric ulcer for periods of more than six weeks.
5. Treatment of gastroesophageal reflux disease. Symptomatic relief commonly occurs within one or two weeks after starting therapy. Therapy for longer than six weeks has not been studied.

In active duodenal ulcer, active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: ZANTAC® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS: General: 1. Symptomatic response to ZANTAC® therapy does not preclude the presence of gastric malignancy.
2. Since ZANTAC is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see **DOSAGE AND ADMINISTRATION**). Caution should be observed in patients with hepatic dysfunction since ZANTAC is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during ZANTAC therapy, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions: Although ZANTAC has been reported to bind weakly to cytochrome P-450 in vitro, recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions which suggest that ZANTAC may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no indication of tumorigenic or carcinogenic effects in lifespan studies in mice and rats at doses up to 2,000 mg/kg/day.

Ranitidine was not mutagenic in standard bacterial tests (*Salmonella, E coli*) for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next nine weeks.

Pregnancy: *Teratogenic Effects*: *Pregnancy Category B*: Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ZANTAC. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: ZANTAC is secreted in human milk. Caution should be exercised when ZANTAC is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Use in Elderly Patients: Ulcer healing rates in elderly patients (65 to 82 years of age) were no different from those in younger age groups. The incidence rates for adverse events and laboratory abnormalities were also not different from those seen in other age groups.

ADVERSE REACTIONS: The following have been reported as events in clinical trials or in the routine management of patients treated with oral ZANTAC®. The relationship to ZANTAC therapy has been unclear in many cases. Headache, sometimes severe, seems to be related to ZANTAC administration.

Central Nervous System: Rarely, malaise, dizziness, somnolence, insomnia, and vertigo. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients.

Cardiovascular: Rare reports of tachycardia, bradycardia, and premature ventricular beats.

Gastrointestinal: Constipation, diarrhea, nausea/vomiting, and abdominal discomfort/pain.

Hepatic: In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid IV for seven days, and in 4 of 24 subjects receiving 50 mg qid IV for five days. With oral administration there have been occasional reports of reversible hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice.

Musculoskeletal: Rare reports of arthralgias.

Hematologic: Rare reports of reversible leukopenia, granulocytopenia, thrombocytopenia, and pancytopenia.

Endocrine: Controlled studies in animals and man have shown no stimulation of any pituitary hormone by ZANTAC and no antiandrogenic activity, and cimetidine-induced gynecomastia and impotence in hypersecretory patients have resolved when ZANTAC has been substituted. However, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving ZANTAC, but the incidence did not differ from that in the general population.

Integumental: Rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia.

Other: Rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia) and small increases in serum creatinine.

OVERDOSAGE: There is no experience to date with deliberate overdosage. The usual measures to remove unabsorbed material from the gastrointestinal tract, clinical monitoring, and supportive therapy should be employed.

Studies in dogs receiving doses of ZANTAC® in excess of 225 mg/kg/day have shown muscular tremors, vomiting, and rapid respiration. Single oral doses of 1,000 mg/kg in mice and rats were not lethal. Intravenous LD_{50} values in rat and mouse were 83 and 77 mg/kg, respectively.

DOSAGE AND ADMINISTRATION: Dosage Adjustment for Patients with Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with ZANTAC®, the recommended dosage in patients with a creatinine clearance less than 50 ml/min is 150 mg every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosage schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: ZANTAC® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 tablets (NDC 0173-0344-42) and unit dose packs of 100 tablets (NDC 0173-0344-47).

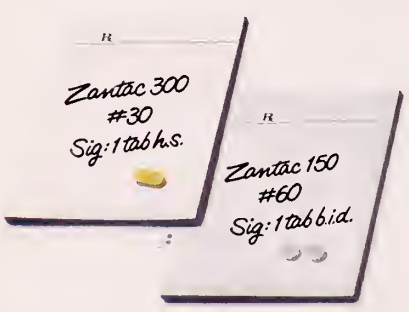
ZANTAC® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) and unit dose packs of 100 tablets (NDC 0173-0393-47).

Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.

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Now...two effective regimens to treat active duodenal ulcers



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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
August 1986, XXVII, Number 8

ORIGINAL PAPERS

Epiglottitis in a Community Hospital

JOHN D. COFFEY, JR., M.D.
Natchez, Mississippi

The author reviews cases of epiglottitis in children in the 25 years since the opening of Jefferson Davis Memorial Hospital in Natchez. Five cases were clearly of infectious etiology, with four proven Hemophilus influenzae type B, and one apparent allergic etiology. Pertinent literature is reviewed. The author emphasizes the importance of early diagnosis and the establishment of an airway, preferably by nasotracheal tube. He discusses appropriate antibiotic therapy and chemoprophylaxis of the carrier state.

ACUTE EPIGLOTTITIS is an inflammatory process involving the supraglottic structures of the larynx, most noticeably the epiglottis, usually due to *Hemophilus influenzae* type B (HIB) and which, unless an artificial airway is established, is usually rapidly progressive, causing respiratory obstruction and death or serious sequelae from hypoxia.

The disease was first described by Sinclair[1] who reported ten cases from the Grace-New Haven Community Hospital, Yale University School of Medicine.

The next significant report was by Rabe[2] who had 18 additional cases of "infectious croup due to *Hemophilus influenzae* type B." This organism was recovered from blood cultures in 89.4% of the cases. These 28 cases reported from New Haven by Sinclair and Rabe characteristically had a brief history of sudden onset of sore throat with prostration and difficult swallowing and respiratory obstruction. Also noted was the thick red epiglottis seen on direct laryngoscopy or simple inspection, along with extension of the head without other signs of meningeal irritation. Temperature elevation and leukocytosis were observed. A tracheotomy was done in half of the cases and two of the patients died. Two non-tracheotomized patients died, these having been in the hospital less than three hours. Rabe stated that tracheotomy is the treatment of choice for relieving the respiratory obstruction because of the basic pathology: supraglottic edema. (Intubation at that time was with the O'Dwyer tubes used for laryngeal diphtheria; the lips of the tube rested on the glottic chink and did not relieve supraglottic obstruction.) Other treatments described in the 1948 report included sulfonamides, type specific rabbit serum, and whole blood transfusions.

Greenberg and Schisgall[3] reported their experience with 21 cases of epiglottitis in a community hospital of 388 beds in Silver Spring, Maryland, from January 1, 1974 through December 31, 1977. The average age of their patients was 4 years, the majority males. The signs and symptoms were as described above, and included drooling. Of 18 patients who had blood cultures, 15 were positive for

Dr. Coffey is engaged in the private practice of pediatrics in Natchez, MS.

HIB. Fourteen had nasotracheal intubation, a 4 to 5 mm Portex tube being inserted in the operating room in most cases, using oxygen, nitrous oxide, and halothane anesthesia. Three patients were intubated without anesthesia because of the severity of their obstruction. The average time for continuing intubation was 40 hours. One child had a tracheotomy in the emergency room because of respiratory arrest. Initial treatment was usually ampicillin and chloramphenicol, the latter discontinued if the organism was ampicillin sensitive. A 4-year-old child developed a mucus plug in her tube with resulting respiratory arrest, but was resuscitated. One child was admitted with a diagnosis of asthma because of stridor along with wheezing. The nasotracheal tubes were left in for an average time of 30 hours in the latter part of the study and direct laryngoscopy was done before removing the tube. (The pediatric fiberoptic laryngoscope is now available for this examination.) The authors noted that there have been about five cases per year for the past four years in their institution and that all physicians and nurses who care for children should be familiar with a protocol for diagnosing and managing upper airway obstruction.



Figure 1. Microscopic sections of supraglottic structures from autopsy on Case 1, showing acute inflammation with edema, congestion, and infiltration with polymorphonuclear leukocytes.

Schultz and Morrison[4] of Memphis report 26 children treated for acute epiglottitis from 1971 to 1979, with diagnoses confirmed by lateral roentgenograms of the neck or direct laryngoscopy. The average age was 3 years, the majority of cases occurring in the fall, winter, and spring. Sixteen consecutive patients were nasotracheally intubated and treated with intravenous ampicillin and chloramphenicol along with dexamethasone. Fifteen of these were successfully extubated in less than 48 hours, significantly decreasing the possibility of complications. The only accidental extubations were in patients with orotracheal tubes. They emphasize the danger of treating these children without establishing an artificial airway.

Faden[5] reported 48 children seen between 1969 and 1977 at Buffalo Children's Hospital with epiglottitis and blood cultures positive for HIB. One child died, and another developed hypoxic brain damage; 95% were intubated; and none required tracheotomy. The endotracheal tubes remained in place for 3.3 ± 1.5 days. Short-term antimicrobial therapy for 4 ± 1.4 days was sufficient to eradicate bacteremia.

Sidney S. Gellis,[6] editor of *Pediatric Notes,* comments on a paper in *Laryngoscope 1983* by Schloss who advocates lateral x-rays of the neck in confirming the diagnosis. Gellis does not see the need for these films.

Claesson et al[7] retrospectively studied epiglottitis in children 0 to 15 years old in the Gothenburg region of Sweden from 1971 through 1980, and 211 patients with well-documented acute epiglottitis were found. The incidence of epiglottitis in their region was higher than the incidence of HIB meningitis. The median age was 4 years. In 186 patients (88%) an artificial airway was established: tracheotomy in 171, intubation in 15. All patients survived.

Epiglottitis due to HIB is not a disease limited to children. Glode et al[8] report 5 cases in adults in Denver over a 16 month period; these were associated with colonization and invasive HIB disease in young contacts. Their oldest case was a 60 year old grandfather who had positive blood and epiglottis cultures for HIB, resistant to ampicillin, treated successfully with chloramphenicol.

Materials and Methods

Jefferson Davis Memorial Hospital opened in Natchez, Mississippi on April 16, 1960, with a 150 bed capacity. In 1971 this was increased to 173

beds, and in 1981 to 205 beds. The cases of epiglottitis diagnosed in children at this hospital during the 25 year period since its opening are reviewed.

Case Reports

Case 1. On April 8, 1971, a 4-year-old male was brought to the emergency room in acute respiratory distress and died before the physician on call could reach the hospital. Immediately after death a laryngoscopic examination showed a markedly edematous epiglottis with obstruction of the glottis. Microscopic sections of the epiglottis after autopsy (see Figure 1) showed acute inflammation with edema, congestion, and infiltrate with polymorphonuclear leukocytes extending into the muscularis. The lungs showed acute edema and congestion. Cultures from the glottis and lungs grew HIB.

Case 2. This 2½-year-old male was admitted on December 13, 1979, with a 5½ hour history of fever, brassy cough, followed by inspiratory stridor and drooling, with rapid development of respiratory fatigue. Physical examination showed an easily visible cherry-red swollen epiglottis. When there was no improvement after racemic epinephrine inhalation prescribed by the otolaryngologist, he was taken to the operating room where, after injection of intramuscular Ketamine, a 4.5 mm orotracheal tube was inserted by the anesthesiologist. His initial white blood count was 20,000/cu mm with 15 bands, 79 segs, 6 lymphocytes. Blood culture was positive for HIB, sensitive to ampicillin and chloramphenicol. Initial treatment was with both antibiotics until sensitivities were reported, then chloramphenicol was discontinued. He developed abdominal distention due to swallowed air. (Children try to swallow orogastric tubes.) After 48 hours, when inspection showed resolution of the supraglottic swelling, the orotracheal tube was removed and he was discharged on December 17, 1979, but was readmitted on August 20, 1980, because of hoarseness. The otolaryngologist found a mild subglottic stenosis on direct laryngoscopy.



Figure 2. Lateral neck x-ray, Case 3, showing swelling of the epiglottis.

Case 3. A 15-month-old male was admitted on December 6, 1983, with a history of rhinorrhea for three days, restlessness the night before admission, and fever the day of admission. The mother noted that he was "croupy" on the afternoon of admission and that he had begun to drool and insert his finger into his mouth along his tongue. Examination showed a classic cherry-red epiglottis with swelling documented on x-ray (see Figure 2). Signs of airway obstruction developed rapidly and a 4 mm nasotracheal tube was inserted by the author in the treatment room. Intravenous ampicillin and chloramphenicol were started, the chloramphenicol being discontinued when the blood culture was reported positive for HIB, sensitive to ampicillin. Intubation was continued for about 68 hours and was discontinued after inspection with a fiberoptic laryngoscope. He has had no further problems.

Case 4. A 3½-year-old female was brought to the emergency room in the early morning of December 29, 1983, with the classical clinical picture of epiglottitis: fever, inability to swallow, and drooling beginning about 5 hours previously. Diagnosis was made by the emergency room physician by physical examination and x-ray (see Figure 3). A blood culture was drawn and an infusion was started. She was seen immediately by the author, who performed an orotracheal intubation in the emergency room because of her increasing respiratory distress. After she was stable, the orotracheal tube was replaced with a 4.5 mm nasotracheal tube. About two hours later she extubated herself and the tube was replaced without difficulty. She rapidly

defervesced while receiving ampicillin and chloramphenicol, the latter antibiotic being discontinued when the blood culture was reported HIB, beta lactamase negative. After 48 hours of intubation, the child became dyspneic due to a plug of mucus in the tube. The tube was removed and there were no further difficulties or residual problems.

Case 5. This 4-year-old female was admitted on December 16, 1984, with a history of having difficulty "catching her breath" a short time before admission. She had no fever and her mother felt that she was having a recurrence of her asthma. The emergency room physician agreed with the mother and started intravenous fluid with aminophyllin and hydrocortisone and inhalations of isoetharine. Her respiratory distress did not improve and the pediatric nurse noted that the child was having more difficulty with inspiration than expiration and the attending pediatrician was called. He made a diagnosis of epiglottitis and called a surgeon and anesthesiologist. An orotracheal tube was inserted, and it was noted that epiglottis was swollen and reddened. The child was treated with intravenous fluid, aminophyllin, and chloramphenicol, along with meperidine and promethazine for sedation. No blood culture was obtained, but Directogen tests on urine and, after 3 days, on blood were negative for HIB. At no time was there a temperature elevation. The orotracheal tube was removed in 3 days and she did well thereafter. It was believed that in view of the absence of fever and toxicity, negative antigen tests for HIB, and the established past history of respiratory allergy, this child's distress and upper airway obstruction were probably due to allergic angioedema of the glottic and supraglottic structures.



Figure 3. Lateral x-ray on Case 4, showing swollen epiglottis.

Case 6. A 3-year-old female was admitted on January 4, 1985, with a 12 hour history of fever, sore throat, and refusal to swallow. No stridor was noted in the hospital record, but she refused to talk and tended to hold her head in a fixed position of extension. Blood culture was not obtained, but a throat culture reported "normal flora." Her pediatrician ordered intravenous fluid and ampicillin. She developed increasing respiratory distress. An otolaryngologist was consulted and he made a diagnosis of epiglottitis and called an anesthesiologist who inserted a nasotracheal tube in the operating room, immediately relieving her distress. Her temperature elevation gradually abated and she was extubated in 3 days and discharged on January 8, 1985.

Discussion

Of the six cases reported, five had clinical evidence of an infectious etiology. In four, HIB was established as the cause. One case appeared to be due to angioneurotic edema. The mean age of the five infectious epiglottic patients was 2.85 years.

During the same time period (April 1971 through January 1985) there were 18 cases of meningitis due to HIB at Jeff Davis Hospital. The mean age of these children was 1.42 years. Our relative numbers of cases of meningitis compared with epiglottitis are more in keeping with reports from the United States than with the report from Sweden.[7]

Our cases required an artificial airway by tracheal intubation, and nasotracheal intubation is the method of choice. The two children with orotracheal tubes were uncomfortable and one (Case 2) had documented abdominal swelling from aerophagia and required a nasogastric tube for relief. It was found that splinting at the elbows was the best way to prevent self-extubation.

The cephalosporins which are effective against

HIB would probably now be the antibiotics of choice. Cefuroxime is listed as the drug of choice by John D. Nelson in the *1985 Pocket Book of Antimicrobial Therapy*. In a personal communication, Russell Steele reported three cases of epiglottitis successfully treated with ceftriaxone at the University of Arkansas Children's Hospital.

Children with invasive disease due to HIB are often nasopharyngeal carriers despite antibiotic therapy and, along with household contacts, should receive rifampin 20 mg/kg/day for 4 days.[9]

Case 1 and the five fatal cases reported by Bass[10] attest to the need for awareness of the rapid course of epiglottitis and the necessity of adequate preparation for securing an airway and for closely monitoring these patients. ★★★

136 Jeff Davis Boulevard (39120)

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For asymptomatic persons the Society recommends annual digital rectal examination at age 40 and over; at age 50 and over, an annual stool blood test, as well as sigmoidoscopy every three to five years, following two initial annual negative sigmoidoscopies.

We're here to help. You can reach us at your local American Cancer Society office or write to our Professional Education Department at National Headquarters, 90 Park Avenue, New York, N.Y. 10016. Ask about the Society's Colorectal Check program of professional and public education for the early detection of colorectal cancer.

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*"Cancer of the Colon and Rectum: Summary of Public Attitude Survey," *Ca* 33:359-365, 1983 (Nov.-Dec.).



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Adventitial Cystic Disease Of The Popliteal Artery: Case Report

JAMES L. BURKHALTER, M.D. and JOHN J. CONNORS, III, M.D.
Jackson, Mississippi

A 23-YEAR-OLD FEMALE presented to our institution with a three to four week history of an enlarging mass associated with an aching pain in her distal right posterior thigh and knee region. Interestingly, she reported subjective paresthesias distal to the mass. There was no history of trauma of any type.

Clinical examination revealed a 6 x 6 cm firm mass in the posterior distal thigh region. There was no abnormality of distal pulses. All laboratory results were within normal limits.

Initial evaluation of this mass included radiographs (see Figure 1) which revealed a soft tissue mass in the described region without obvious osseous abnormality. A three-phase bone scan (see Figure 2) revealed a hypovascular mass in the described region without altered radionuclide uptake in the adjacent bone. A CT scan (see Figure 3) performed both before and after intravenous contrast administration revealed a well circumscribed homogeneous mass without significant enhancement which appeared to be slightly more dense (by approximately 13 HU) than the nearby muscle tissue. The mass was posterior to the femur and did not appear to be connected with it. The neurovascular bundle could not be identified as a separate structure.

Arteriography was then performed (see Figure 4) which revealed a hypovascular mass which displaced the popliteal artery anteriorly. In the arterial and capillary phases small vessels were noted at the margin of the mass, particularly in its superior portion, but were not felt to represent neovascularity. Additional use of digital subtraction technique allowed further evaluation of the vascularity of this mass and revealed some slight blush in the upper border as described above, as well as minimal vascularity in the inferior margin.



Figure 1. Lateral right knee film reveals an oval 5 cm x 8 cm soft tissue mass without calcification or adjacent bony distortion in the posterior distal thigh region.

Surgical exploration and excisional biopsy was performed.

From the Department of Radiology, University Medical Center, Jackson, MS.



Figure 2. Blood pool imaging during radionuclide bone scanning. Lateral views of each knee demonstrate an unremarkable appearance of the left knee, but in the area of the mass there is a focus of decreased radiotracer blood pool activity with increased activity above and below it.

Diagnosis

The diagnosis was adventitial cystic disease of the popliteal artery. Differential diagnosis includes popliteal aneurysm with thrombosis, popliteal pseudo-aneurysm with thrombosis (jogger's aneurysm), soft tissue tumor, and lymph node enlargement.

Exploration revealed the mass to be bluish and soft, containing very dark thick fluid felt to be old blood. The cystic mass extended down to the popliteal artery and was adherent to the vessels themselves with no identifiable plane between them. The bulk of the mass was removed, leaving a small portion attached to the vessel itself. The pathological diagnosis was adventitial cyst of the popliteal artery.

Discussion

Within the last decade several references have summarized the findings in over 100 cases of adventitial cystic disease of the popliteal artery. Initially described in 1954,[3] the most recent extensive review of the literature was 1979.[4] Typically the patient is male in his third to sixth decade of life;[6] it occurs only rarely in children.[2] The typical clinical presentation is that of relatively sudden onset of cramping pain in the calf, followed by the development of intermittent claudication. While signs of ischemia are present, they may sometimes only be

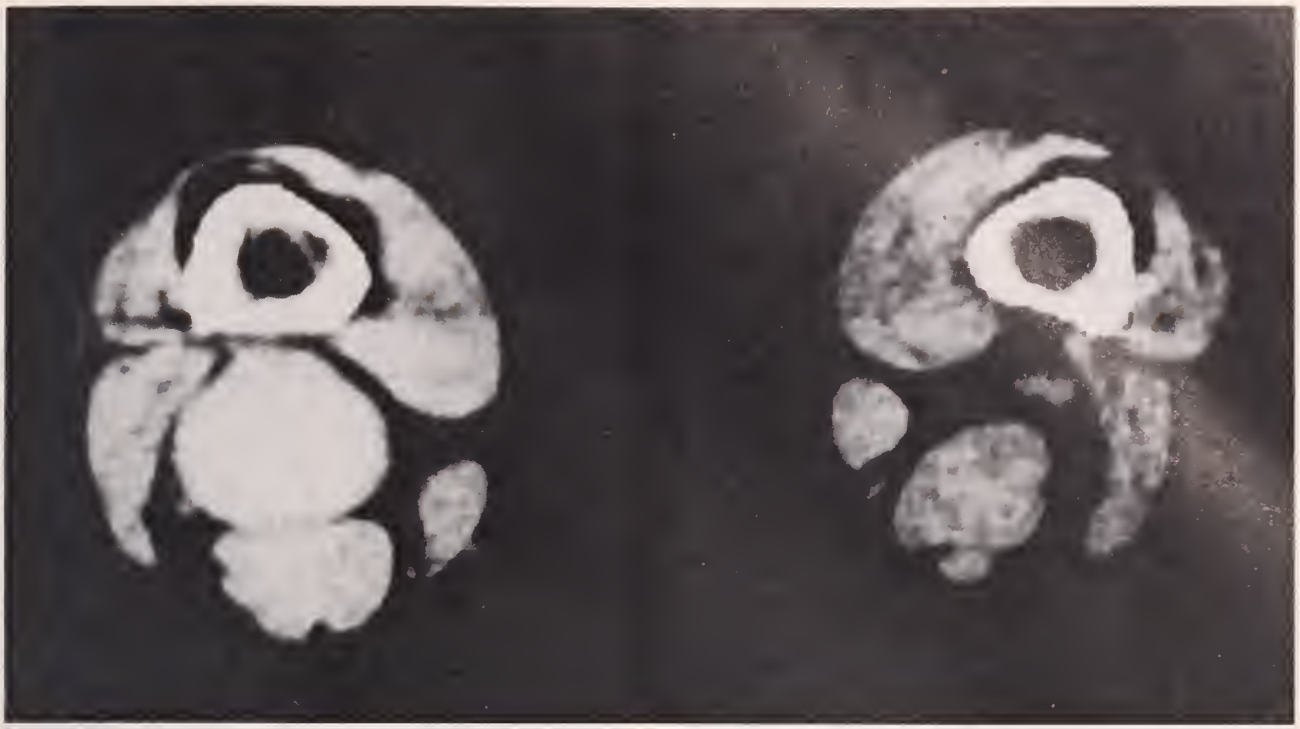


Figure 3. CT scan of both distal thighs reveals a well circumscribed homogeneous mass without significant enhancement posterior to the right femur and which appears slightly more dense (by approximately 13 HU) than the nearby muscle tissue. The mass was posterior to the femur and did not appear to be connected with it.

obvious on exertion and may be exacerbated by full flexion of the knee.[4, 5] Our case is somewhat unusual in that it occurred in a young female without symptoms of claudication and presented as a painful mass in the region of the knee.

If the lesion is of sufficient size, it may be demonstrable as a nondescript soft tissue mass on plane films, as in our case. With the history of claudication in an otherwise healthy young patient, arteriography is usually the next diagnostic study obtained. This usually demonstrates a smooth-walled stenosis or complete obstruction in the popliteal artery with an otherwise normal arterial tree. There are fewer collateral vessels than seen in the usual case of atherosclerotic occlusions and the occlusion or severe stenotic lesion may have a cup-shaped defect termed the "scimitar" sign.[4] Our case demonstrated the close proximity of the described soft tissue mass to the popliteal artery and the associated distorted appearance of the popliteal artery. Adjacent displacement of small arteries and veins was well demonstrated both by routine angiography and digital subtraction angiographic technique.

While the computed tomographic and ultrasonic evaluation of adventitial cystic disease of the popliteal artery has been described,[7] the appearance on the nuclear medicine images has, to the best of our knowledge, not been previously described. The transverse CT sections usually demonstrate a soft tissue mass inseparable from the neurovascular bundle of the popliteal artery and vein with CT attentuation values somewhat lower than muscle and flowing blood. In our case the CT numbers were slightly higher than the adjacent muscle, likely the result of hemorrhage into the cyst. CT scan can also on occasion outline an ovoid mass causing eccentric compression of the arterial lumen. Ultrasound evaluation often demonstrates a fusiform mass with its long axis oriented along the wall of the popliteal artery. The arterial lumen may be narrowed but patent or intermittently occluded. The mass may be anechoic or contain scattered low level echoes.[1, 7] In our case a three-phase bone scan of this region demonstrated a hypovascular mass with slight increase in blood pool activity in the adjacent soft tissues but without associated altered radionuclide uptake in the adjacent bone and no evidence of other lesions. With the unusual clinical presentation in this case, the evaluation of a nondescript soft tissue mass in an extremity in a young patient should include a three-phase bone scan, considering that soft tissue neoplasms of various types would remain a primary consideration.



Figure 4. Lateral arteriogram. Demonstrated is some relative widening of the popliteal artery in the region of the mass, suggesting effacement by the mass. The venous phase image reveals draping of veins around the mass with slight pooling of contrast within these veins. No neovascularity or arteriovenous shunting is seen.

Pathologically the lesion consists of a unilocular or multilocular cyst present within the wall of the popliteal artery, often compressing the lumen.[4] The described cyst contents vary but are mostly rich in hyaluronic acid radicals, supporting the theory that the mucin of the cyst is more likely of ground substance nature, rather than secreted by epithelial cells.[4] The etiology of such lesions remains open to discussion, with perhaps the preferred theory being that of joint capsular degeneration producing connective tissue changes in which cells secrete a substance, hydroxylene, derived from ground substance or collagen. These cells then form cysts which invade the adventitia and over a period of time enlarge to produce the symptoms described above. Other theories as to the origin of this entity include adventitial degeneration, micro-trauma, and the possibililty that the cysts themselves actually represent true ganglia.[4]

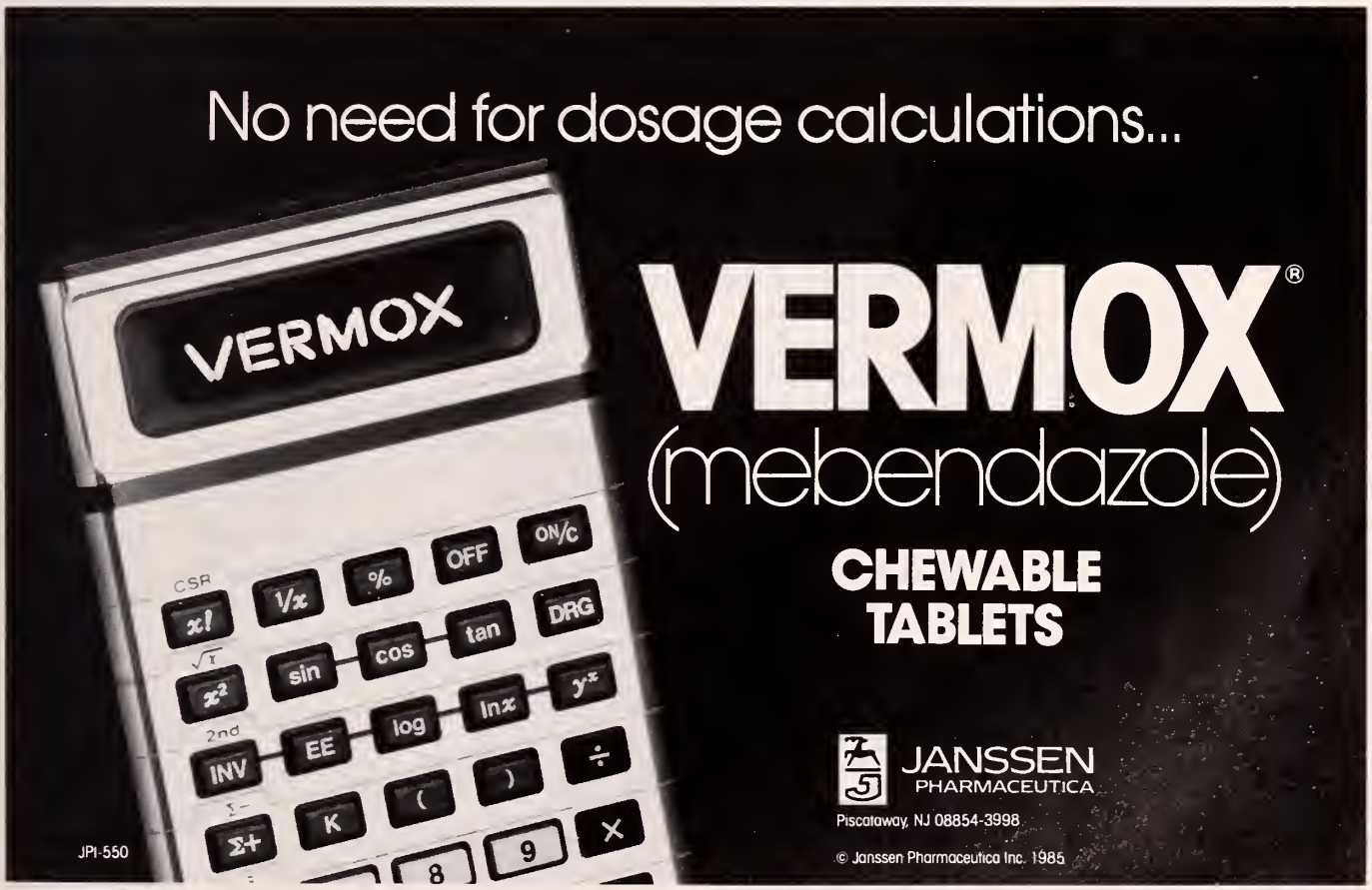
In most cases treatment of this disorder usually requires surgical intervention. If the artery is patent, incisional evacuation of the cyst apparently is curative; if the artery is occluded, grafting may be necessary. In the reported cases in the literature, surgical results have been very good.[4]

In summary, the presentation of this young female patient with a painful mass in the distal thigh is unusual for adventitial cystic disease of the popliteal artery; the usual presentation being symptoms of intermittent claudication, in patients below the age for atherosclerotic disease. It is an unusual condition of debatable etiology in which there is a mucin-containing cyst which forms in the wall of the popliteal artery and for which surgery, either evacuation or excision, is curative. ★★★

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The President Speaking

Where We've Been — Where We're Going

W. JOSEPH H. BURNETT, M.D.
Oxford, Mississippi

We can all be proud of the great strides in medicine during our lifetime. Many of our accomplishments are the result of research, physician and community education, and the physicians' voices demanding quality care. How well have these advances served us?

As a nation we are healthier than ever. Our average life expectancy is 74.7 years compared to 69.7 years just 25 years ago. Death and disability from heart attacks, stroke, and cancer are decreasing. Infant mortality rates have dropped more than 50% in the past 25 years. Children enjoy new freedom from the once familiar childhood diseases of measles, mumps, and polio. The vitality of middle age has been extended into the fifth and sixth decades, while the elderly can experience notable improvements in the quality of their lives.

Today we take better care of ourselves, thanks in part to increased health education efforts. Medicine has also made great strides in developing new techniques and therapies for combating disease. For example, the laser beam and computer now are adjuncts to many medical processes. Advanced x-ray techniques have greatly enhanced our ability to detect and treat physical abnormalities. Plastics and other synthetic materials extend our healing arm far beyond previous limits. Drugs unknown only 25 years ago make up more than 90% of the modern pharmaceutical arsenal. Just as important, medical research holds the promise of continued breakthroughs that can benefit all of us far into the future.

The demands for quality care have brought us to these heights. The efforts of our dedicated physicians can keep medicine not only well defined and efficient, but also personalized and caring. We must always remember "medicine is more than just curing — it's caring." Continuing to care, and insistence on quality will take medicine to even greater heights.

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XXVII, NUMBER 8

AUGUST 1986

"Baby Doe" Decision Clarifies Responsibility in Treatment Decisions

The recent United States Supreme Court decision in the "Baby Doe" case generated much discussion from both sides of the issue. Organized medicine hailed it as a great victory, reconfirming the long-standing concept that the practice of medicine should be left to those properly trained and licensed in the profession. Those opposing this decision have gone so far as to claim it gives physicians the right to withhold treatment, thus "giving them the right to commit murder."

It is proper that such decisions be left to the professionals. It is also true that this professional privilege will be more strongly scrutinized than ever before.

Winning the court battle does not end the conflict. To preserve the victory medicine must act responsibly. Physicians will have to show concern and compassion in these situations. Decisions in such cases must be made after consultation with other professionals, family members, and in some cases with members of other professions. We have won the battle; now, let's not lose the war by acting irresponsibly in such cases.

MYRON W. LOCKEY, M.D.
Editor

Medico-Legal Brief

Withholding or Withdrawing Life Prolonging Medical Treatment

The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the choice of the patient, or his family or legal representative if the patient is incompetent to act in his own behalf, should prevail. In the absence of the patient's choice or an authorized proxy, the physician must act in the best interest of the patient.

For humane reasons, with informed consent, a physician may do what is medically necessary to alleviate severe pain, or cease or omit treatment to permit a terminally ill patient whose death is imminent to die. However, he should not intentionally cause death. In deciding whether the administration of potentially life-prolonging medical treatment is in the best interest of the patient who is incompetent to act in his own behalf, the physician should determine what the possibility is for extending life under humane and comfortable conditions and what are the prior expressed wishes of the patient and attitudes of the family or those who have responsibility for the custody of the patient.

Even if death is not imminent but a patient's coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis and with the concurrence of those who have responsibility for the care of the patient, it is not unethical to discontinue all means of life-prolonging medical treatment.

Life-prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration. In treating a terminally ill or irreversibly comatose patient, the physician should determine whether the benefits of treatment outweigh its burdens. At all times, the dignity of the patient should be maintained. (*Opinion of the AMA Council on Ethical and Judicial Affairs.*)

The editors invite your comments, inquiries, and suggestions. Please address letters to the Editors, *Journal of the Mississippi State Medical Association*, P.O. Box 5229, Jackson, MS 39216.

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MAFP Announces New Officers

Dr. Leonard H. Brandon of Starkville was installed as the 39th president of the Mississippi Academy of Family Physicians at the academy's recent annual scientific assembly in Biloxi.

Dr. Richard C. Inskip, president of the American Academy of Family Physicians, conducted the installation of Dr. Brandon and other MAFP officers including: Dr. Walter Gunn of Quitman, president-elect; Dr. Malcolm Moore of Tupelo, vice president; Dr. George Bush of Laurel, secretary-treasurer.

Five physicians were installed as directors, including: Dr. John Hassell of Laurel; Dr. John Paul Lee of Forest; Dr. George Abraham of Vicksburg; Dr. Stanley Hartness of Kosciusko; and Dr. Nell Moore of Tupelo.

Dr. Max L. Pharr of Jackson received the John B. Howell Memorial Award for Family Doctor of the Year. The award is given for outstanding leadership and services to family medicine in Mississippi. The MAFP Memorial Award was presented to Cherry Clarke, a 1986 graduate of the Family Medicine Residency Program at the University of Mississippi Medical Center.

UMC Announces Faculty Promotions

Seventeen have been named in faculty promotions at the University of Mississippi Medical Center for the coming academic session.

Dr. Norman C. Nelson, UMC vice chancellor for health affairs, announced the promotions following approval of the Board of Trustees of State Institutions of Higher Learning. The appointments included 13 in the School of Medicine, one in the School of Health Related Professions, and three centerwide.

Promoted to the rank of professor in the medical school were Dr. Bernard Dreiling, professor of medicine; Dr. Alan E. Freeland, professor of surgery (orthopedics); Dr. Richard G. Hutchinson, professor of medicine; and Dr. Edward F. Meydrech, professor of preventive medicine (biostatistics). Dr. Arthur S. Hume was named professor of pharmacology/toxicology in centerwide promotions.

Named associate professor in the School of Medicine were Dr. Bryan D. Cowan, obstetrics/gynecology; Dr. Patricia M. Dubbert, psychiatry and human behavior; Dr. Joe C. Files, medicine (hematology); Dr. Rathi I. Iyer, pediatrics; Dr. Patricia Norman, anesthesiology; Dr. Paul H. Parker, pediatrics; Dr. William F. Russell, radiology; Dr. Robert Rychtarik, psychiatry and human behavior; and Dr. Ralph B. Vance, medicine (oncology). Centerwide, Dr. Jonathan B. Chaires was named associate professor of biochemistry, and Dr. Durisala Desaiah, associate professor of pharmacology/toxicology.

Paul I. Hicock, Jr., was promoted to associate professor of medical technology in the health related professions school.

Top Medical School Graduate Receives Leathers Award



Dr. Angela Dickson Graeber, earned the M.D. summa cum laude in University of Mississippi Medical Center Commencement exercises. She received the University's Leathers Award as the graduating medical student with the highest academic average. Dr. Norman C. Nelson, left, is UMC vice chancellor for health affairs. Dr. Graeber is the daughter of Mr. Charles R. Dickson of Memphis and Mrs. Etta Dickson of Germantown, Tennessee.

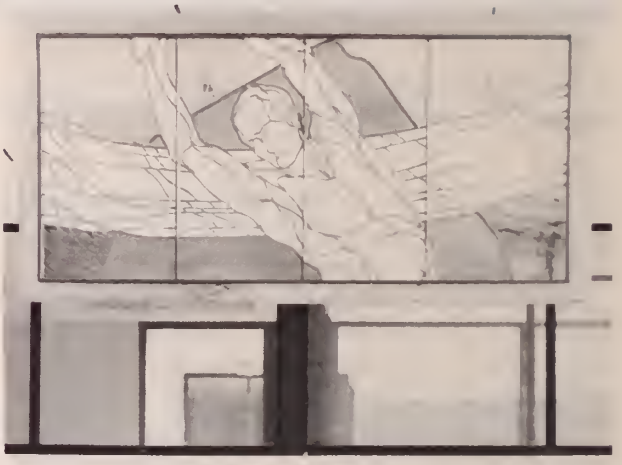
MSMA Presents Outstanding Health Related Profession Award



Clara Bessie Ramos, daughter of Mr. and Mrs. Jorge A. Ramos of Jackson, earned the B.S. in medical technology summa cum laude in University of Mississippi Medical Center Commencement exercises. She received the Health Related Professions Award as the outstanding health related professions student. Dr. Thomas E. Freeland, left, is dean of the School of Health Related Professions. Dr. Carl Evers, right, is medical school associate dean for academilc affairs and speaker of the House of Delegates for the Mississippi State Medical Association, which sponsors the annual award.

JOIN MPAC TODAY

Stained Glass Collection Dedicated at UMC





The stained glass panel, at top of photo, is one in a series of five presented to the University of Mississippi Medical Center by the Medical Center Women's Club in ceremonies in the university's Rowland Medical Library. The series, entitled "Render the Spirit," was created by noted Mississippi artist Andy Young, and commissioned by MCWC. Present for the ceremonies were Dr. Norman C. Nelson, UMC vice chancellor for health affairs, who accepted the gift for the Medical Center; library director Irene Graham; Andy Young; and Dr. Ralph Brock of McComb, then MSMA president.

Next Month in *JOURNAL MSMA*

Address of the President

"Craniocerebral Trauma and the Primary Physician"

"Mortality in Bleeding and Perforated Peptic Ulcer"


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Jaquith Award Recipient Honored



Dr. Andrew C. Bishop (third left), was the 1986 recipient of the William Jaquith Award presented by the Department of Psychiatry and Human Behavior at the University of Mississippi Medical Center. The award, named in honor of the former director of the State Hospital at Whitfield, was presented by Dr. James Stubbs, who is the current director at second right. It goes to the UMC psychiatry resident who shows the greatest professional promise during postgraduate training. With Dr. Bishop are from left, his parents, Mr. and Mrs. Charles F. Bishop of Decatur, and at right, Dr. Edgar Draper, UMC professor of psychiatry and human behavior and director of the department.

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PERSONALS

GEORGE ABRAHAM II of Vicksburg has been elected to the board of directors of the American Diabetes Association, Mississippi Affiliate.

JAMES ACHORD of UMC has been appointed to serve on the gastroenterology subcommittee for the American College of Physicians' project on delineating clinical privileges.

W. O. BARNETT of Jackson spoke at the International Association of Enterostomal Therapists annual conference in Washington, DC.

GENE BARRETT of Jackson spoke at the National Association of Orthopaedic Nurses meeting in New Orleans and at the American College of Sports Medicine meeting in Indianapolis, Indiana.

G. O. BERRYHILL, JR. announces the opening of his office for the practice of internal medicine at 1819 Hospital Drive in Clarksdale.

AUSTIN P. BOGGAN of Decatur has been recertified by the American Academy of Family Physicians.

RALPH BROCK of McComb recently was honored by the board of trustees of Southwest Mississippi Regional Medical Center.

CURTIS ANDREW BROUSSARD announces his association in family practice with the Family Medical Clinic of Orange Grove and Gulfport.

JIMMY R. CHISM announces the opening of his office for the practice of obstetrics, gynecology and infertility at 400 Doctor's Drive in New Albany.

ROBERT E. CLARK has associated with Internal Medicine Clinic of Meridian for the practice of nephrology and internal medicine.

WEIR CONNER of Jackson spoke at the St. Elizabeth-Anne Guild of St. James Episcopal Church on the subject of behavior management, school readiness and common developmental problems.

JACK D. DANIEL, RICHARD A. JOHNSON and RANDOLPH J. ROSS of Hattiesburg announce the opening of their office for medical and surgical treatment of genital, urinary and kidney diseases (Southern Kidney Center) at 3005 Highway 15 North in Laurel.

JOHN EVANS of Tupelo was co-author of "Osteogenic Sarcoma of the Prostate" for the *Journal of Pathology*.

RICHARD J. FIELD, JR. of Centreville spoke at the Ohio Chapter of the American College of Surgeons in Toledo in May.

J. D. FLY of Jackson has been named president-elect of the Mississippi Affiliate of the American Diabetes Association.

ALAN E. FREELAND of UMC led an American delegation of orthopedic surgeons to China and Hong Kong.

THOMAS S. GLASGOW and WILLIAM A. SPENCER of Oxford announce their association with Oxford Family Medicine Clinic, 2161 South Lamar Boulevard in Oxford.

JIM GORDON of Tupelo was speaker at the Mississippi Association of Family Practice. His subject was "Recent Advances in Urology."

JOHN R. HARPER of Taylorsville has been recertified by the American Academy of Family Physicians.

KENNETH J. HAYLES announces the opening of his office for the practice of ophthalmology at 1316 Hospital Street in Greenville.

BENTON M. HILBUN and LUCAS PLATT of Tupelo authored a paper on "Acute Appendicitis Presenting as a Scrotal Abscess" for the *Journal of Urology*.

WILLIAM G. JACKSON of Corinth has been recertified by the American Academy of Family Physicians.

GILBERT MASON of Biloxi has been recertified by the American Academy of Family Physicians.

BARRY MCCRAW announces the opening of his office for the practice of pediatrics and adolescent medicine at Aberdeen Medical Clinic, 501 South Chestnut Street in Aberdeen.

WILLIAM MCKELL announces the opening of his office for the practice of internal medicine and gastroenterology at Doctor's Plaza, 105 Hillcrest Road in Houston.

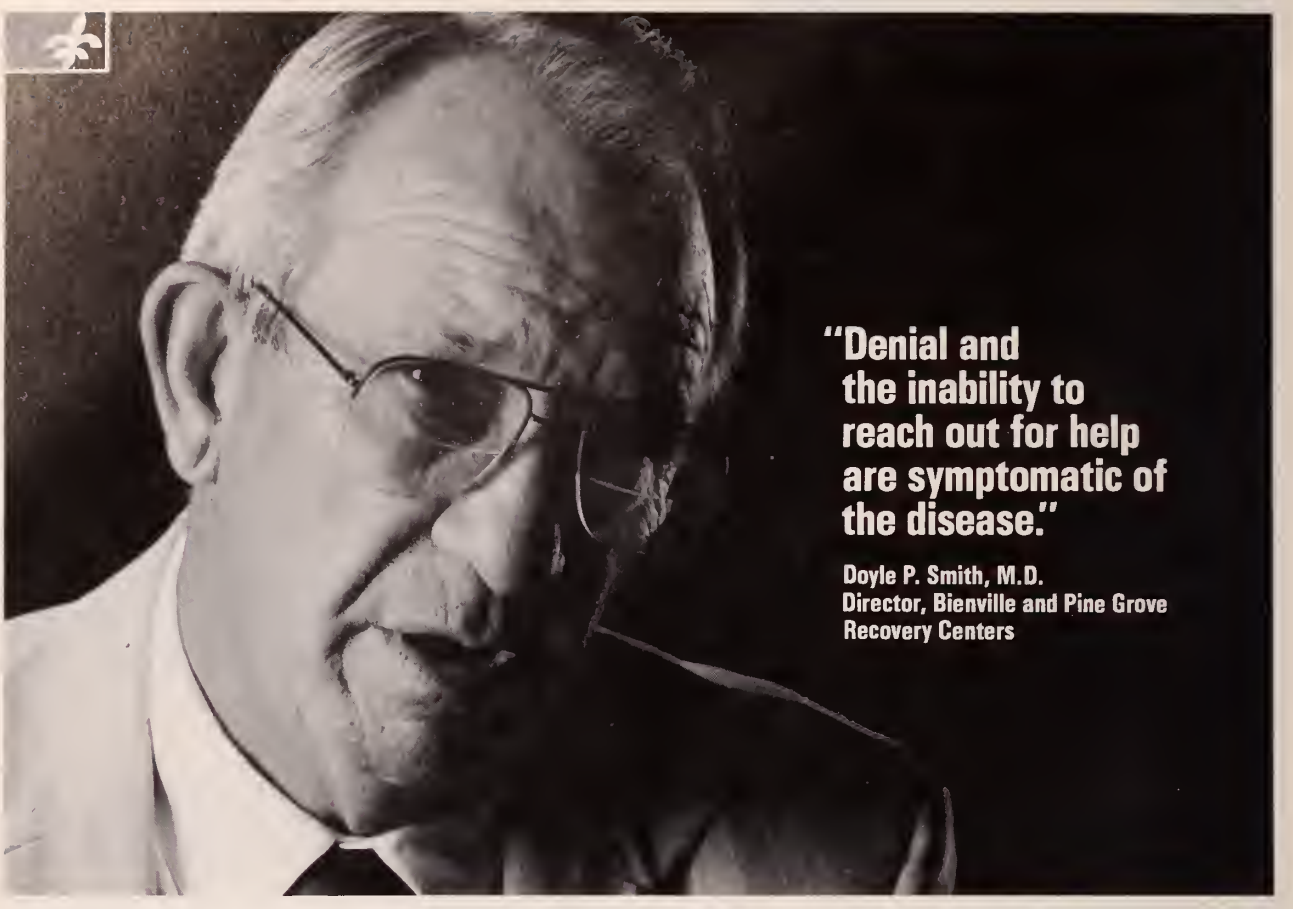
BEVERLY MCMILLAN of Jackson recently spoke at First United Methodist Church in Brookhaven.

JOSEPH K. MINDER announces the opening of his office for the practice of urology at 561 Medical Drive in Clarksdale.

NINA MOFFITT of Jackson was speaker at a seminar in Columbus on women's health issues.

R. J. MOORHEAD of Yazoo City recently was honored by the city's Board of Mayor and Aldermen upon his retirement from practice.

DARDEN H. NORTH has associated with Jackson



Chemical dependency is a disease. Like pneumonia, diabetes, or cancer. And like those diseases, it can be treated. When your patients need treatment for a specialized medical disorder, you refer them to a specialist in that field. Why should the disease of chemical dependency be treated differently?

The specialists in addictive diseases.

Bienville Recovery Center (formerly Biloxi Regional Outreach) is unlike any other chemical dependency treatment center on the Mississippi Gulf Coast. The physicians who staff Bienville are *specialists* in the treatment of addictive diseases. They direct, coordinate, implement, and participate in treatment of alcoholism and drug addiction. Their treatment team includes nurses, clinical assistants, a consulting psychiatrist, a clinical psychologist, a social worker, an alcohol and drug counselor, an aftercare coordinator, a family counselor, a family coordinator, a certified recreational therapist, and an employee assistance program coordinator.

"On-call" vs. "On-staff"

At Bienville Recovery Center, the doctors in charge of treatment are actively involved in the treatment process round the clock. They're not just "on-call" or "available." The treatment of addictive diseases is their lives' work and they practice it daily. With a highly trained and professional staff, they offer hope to the chemically dependent and their families.

A tradition of success.

Bienville Recovery Center is operated by South Mississippi Health Services and is affiliated with the successful Pine Grove Recovery Center in Hattiesburg, Mississippi. Bienville is situated on beautifully landscaped, rolling grounds that face the Gulf of Mexico in Biloxi, Mississippi. Thirty patients are accommodated in the 30-day residential program. Patios, courtyards, and a pool contribute to the therapeutic, non-clinical surroundings, as do the spacious and well-appointed rooms.

Hope for recovery. It's worth a phone call.

If you have chemically dependent patients, Bienville Recovery Center can help them back to alcohol- or drug-free lives. The advantages of a physician-directed and administered treatment program are only a phone call away. Call now. Your patients and their families will thank you.

Toll-free 1-800-523-6267
(in Mississippi)

Bienville Recovery Center

***Complete** care by physicians and staff trained in chemical dependency*

401 East Beach Blvd.
Biloxi, Mississippi 39533

(Formerly Biloxi Regional Outreach)

Clinic for Women for the practice of obstetrics and gynecology.

EDWIN ORR announces the opening of his practice of internal medicine at 124 South Main Street in Sardis.

JUDITH PARKER and DENNIS ROWLEN of Brandon announce the association of CHRISTOPHER E. SMITH and VAN D. STONE for the practice of pediatrics at 210 Clinton Plaza in Clinton.

CHARLES PARKMAN of Hattiesburg was installed as the Mississippi Thoracic Society's Representative Councilor to the American Thoracic Society at the ATS annual meeting in Kansas City.

MILTON T. PERSON of Greenwood announces his retirement from the practice of medicine.

WILLIAM C. PORTER has associated with Vicksburg Clinic for the practice of orthopedics and sports medicine.

SESHADRI RAJU of UMC has accepted an invitation by the Uniformed Services University of Health Sciences to serve as a member of the International Advisory Committee for the fourth European/American Symposium on Venous Diseases.

CALVIN RAMSEY announces the opening of his office for the practice of internal medicine at 500-A East Woodrow Wilson Drive in Jackson.

TERESA REGAN announces the opening of her office for the practice of general medicine and obstetrics at Medical Arts Building in Meadville.

ANDREA S. SMITH announces the opening of her office for the practice of internal medicine at 221 First Street in Clarksdale.

HORTON TAYLOR of Ripley has been named assistant clinical professor of family medicine at UMC.

P. K. THOMAS of Tupelo has been honored by citizens of the area with their contributions to endow the P. K. Thomas Obstetrics Unit at the North Mississippi Women's Health Center.

RALPH VANCE of UMC received the J. Tate Thigpen Award presented by the Central Mississippi Chapter of the American Red Cross. The award recognizes exceptional service to Red Cross programs.

JOHN R. WOOLEY has associated with The Woman's Clinic, 953 North Street in Jackson, for the practice of obstetrics and gynecology.

NEW MEMBERS

ARRIOLA, RODOLFO N., Fulton. Born Philippines, March 3, 1941; M.D., University of St. Tomas Faculty of Medicine and Surgery, Philippines, 1967; interned Columbia Hospital, Pittsburgh, PA, one year; surgery residency, same, 1969-72, Doctors Hospital, Welch, WV, 1972-73, and Columbia Hospital, Pittsburgh, 1974-76; elected by Northeast Mississippi Medical Society.

BENSON, CHRIS H., Hattiesburg. Born Montgomery, AL, Sept. 14, 1952; M.D., University of Alabama School of Medicine, Birmingham, 1978; interned and medicine residency, University of Mississippi School of Medicine, Jackson, 1978-83; fellowship in rheumatology, same, 1981-83; elected by South Mississippi Medical Society.

BORUM, CHARLES D., Natchez. Born Natchez, Feb. 20, 1956; M.D., University of Mississippi School of Medicine, Jackson, 1983; interned Tulsa Medical College Hospital, Tulsa, OK, one year; family prac-

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tice residency, James Phillips Hospital, Bartlesville, OK, 1984-86; elected by Homochitto Valley Medical Society.

Bruce, David L., Jackson. Born Champaign, IL, Oct. 27, 1933; M.D., University of Illinois at Chicago Health Sciences Center, 1960; interned, same, one year; anesthesiology residency, University of Pennsylvania, Philadelphia, 1961-64; elected by Central Medical Society.

Davison, James Marshall, Corinth. Born Boone County, MO, June 17, 1951; D.O., Kirksville College of Osteopathic Medicine, Kirksville, MO 1979; interned and ob-gyn residency, Akron General Medical Center, Akron, OH, 1979-83; elected by Northeast Mississippi Medical Society.

Durel, Cal, Oxford. Born New Orleans, June 24, 1954; M.D., Tulane University School of Medicine, New Orleans, 1981; interned and anesthesiology residency, University of Texas Medical Branch, Galveston, 1981-84; elected by North Mississippi Medical Society

Feldman, Arnold Erwin, Natchez. Born Philadelphia, PA, Dec. 24, 1954; M.D., Medical College of Pennsylvania, Philadelphia, 1980; interned and anesthesiology residency, Thomas Jefferson University Hospital, Philadelphia, 1980-83; elected by Homochitto Valley Medical Society.

Frenz, John Allen, Brandon. Born Canton, OH, Oct. 23, 1941; M.D., Ohio State University College of Medicine, Columbus, 1968; interned and surgery residency, Riverside Methodist Hospital, Columbus, 1968-69; neurosurgery residency, Mercy Hospital, Pittsburgh, PA, 1969-74; elected by Central Medical Society.

Gomez, Gloria, Meridian. Born Philippines, June 14, 1942; M.D., University of San Tomas Faculty of Medicine and Surgery, Philippines, 1968; interned, same, 1967-68; pediatric residency, University of Medicine and Dentistry of New Jersey, 1978-80; neonatology fellowship, same, 1980-82; elected by East Mississippi Medical Society.

Harris, James Earl, Laurel. Born Hollandale, MS, Sept. 5, 1928; M.D., Tulane University School of Medicine, New Orleans, 1955; interned University of Mississippi Medical Center, Jackson, one year; otolaryngology residency, University of Alabama, Birmingham, 1958-61; elected by South Mississippi Medical Society.

Henry, Susan E., Tupelo. Born Jackson, MS, April 2, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned and general surgery residency, University Medical Center, Jackson, 1977-82; fellowship in plastic and reconstructive surgery, same, 1983-85; elected by Northeast Mississippi Medical Society.

Hensley, Michael F., Biloxi. Born Dallas, March 13, 1940, D.O., Kansas City College of Osteopathic Medicine, Kansas City, MO 1971; interned Wright-Patterson Medical Center, Fairborn, OH, one year; pediatric residency, Childrens Mercy Hospital, Kansas City, 1972-74; pediatric hematology and oncology fellowship, M.D. Anderson Medical Center, Houston, TX, 1975-77; elected by Coast Counties Medical Society.

Hicks, W. Merrill, Jr., Greenwood. Born Greenwood, MS, Jan. 9, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned Vanderbilt University, Nashville, one year; internal medicine, same, 1976-79; elected by Delta Medical Society.

Hodges, James M., Hattiesburg. Born Leakesville, MS, Dec. 21, 1951; M.D., University of Alabama School of Medicine, Birmingham, 1976; interned Keesler Medical Center, Biloxi, one year; otolaryngology residency, Walter Reed Army Hospital, Washington, DC, 1977-81; elected by South Mississippi Medical Society.

Jackson, Richard Terry, Jackson. Born Memphis, Nov. 17, 1955; M.D., University of Mississippi School of Medicine, Jackson, 1981; interned and medicine residency, same, 1981-85; elected by Central Medical Society.

Kellum, William Carl, Jr., Tupelo. Born New Orleans, Dec. 2, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned, medicine residency and gastroenterology fellowship, Ochsner Foundation Hospital, New Orleans, 1979-85; elected by Northeast Mississippi Medical Society.

Marcy, William L., Tupelo. Born Memphis, March 28, 1952; M.D., University of Tennessee Center for Health Sciences, Memphis, 1978; interned and family practice residency, same, 1978-81; elected by Northeast Mississippi Medical Society.

McLaurin, Clyde Ray, Canton. Born Jackson, MS, Oct. 12, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned, same, 1981-82; family practice residency, Cleveland Hospital, Cleveland, OH, 1982-84; elected by Central Medical Society.

Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

BRS-DZ:L42

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Serum K^+ and BUN should be checked periodically (see Warnings and Precautions).



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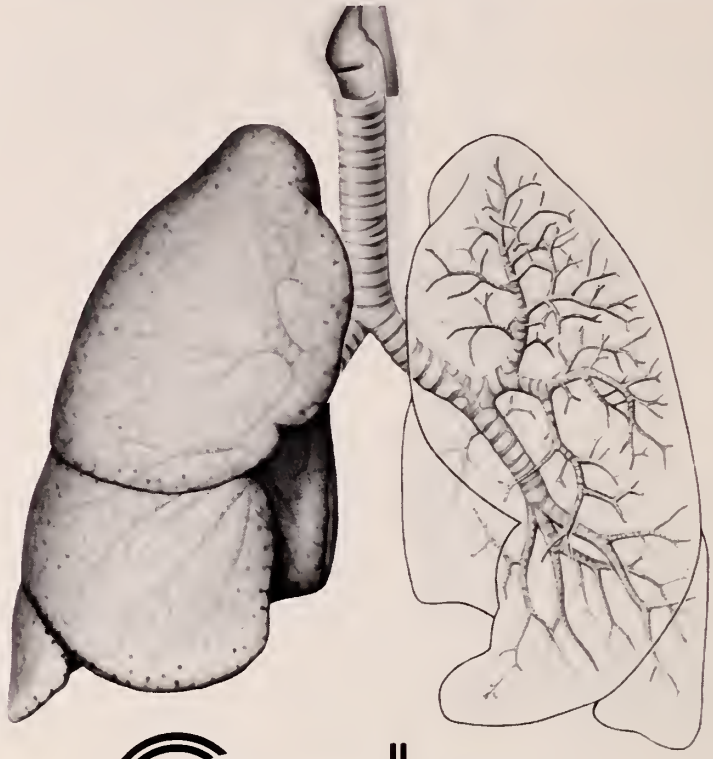
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Consider the causative organisms...



Ceclor®
cefaclor

250-mg Pulvules® t.i.d. offers effectiveness against the major causes of bacterial bronchitis

Haemophilus influenzae*, *H influenzae*, *Streptococcus pneumoniae*, *Streptococcus pyogenes
(ampicillin-susceptible) (ampicillin-resistant)

Note: Ceclor® is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Ceclor® (cefaclor)

Summary. Consult the package literature for prescribing information.

Indications: Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae, Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci).

Contraindications: Known allergy to cephalosporins.

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- In renal impairment, safe dosage of Ceclor may be lower than that usually recommended. Ceclor should be administered with caution in such patients.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, erythema multiforme, serum-sickness-like reactions): 1.5%; usually subside within a few days after cessation of therapy. These reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children)
- Abnormal urinalysis; elevations in BUN or serum creatinine
- Positive direct Coombs' test
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly)

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

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MEHTA, USHA J., Batesville. Born India, Aug. 4, 1953; M.D., M.P. Shsh Medical College, India, 1978; interned City Hospital Center, Elmhurst, NY, one year; ob-gyn residency, Mt. Sinai Hospital, Chicago, 1981-82; and St. Francis General Hospital, Pittsburgh, PA, 1982-84; elected by North Mississippi Medical Society.

PASCO, PATRICK J., Magee. Born Newark, NJ, July 22, 1942; D.O., North Texas State University College of Osteopathic Medicine, 1975; interned University Medical Center, Jackson, MS, one year; elected by Central Medical Society.

PATEL, BHARAT R., Laurel. Born India, Aug. 15, 1948; M.D., Medical College, University of Baroda, India, 1971; interned, same, one year; one year family practice residency, Forrest City Hospital, Cleveland, OH, 1974-75; elected by South Mississippi Medical Society.

POWERS, ROBERT E., Oxford. Born Greenwood, MS, Oct. 1, 1955; M.D., University of Mississippi School of Medicine, Jackson, 1981; interned and anesthesiology residency, University of Texas Medical Branch, Galveston, 1981-84; elected by North Mississippi Medical Society.

PUROHIT, P. R., Batesville. Born Bombay, India, Sept. 21, 1941; M.D., India 1967; interned, same, one year; ob-gyn residency; elected by North Mississippi Medical Society.

PUROHIT, R. C., Batesville. Born India, March 8, 1938; M.D., Medical College, Nagpur, India 1964; interned, one year, same; surgery residency, Worchester, MA, 1971-75; elected by North Mississippi Medical Society.

RICHARDSON, SAMUEL M., III, Pascagoula. Born Minden, LA, July 7, 1942; M.D., Louisiana State University School of Medicine, New Orleans, 1967; interned, Pensacola, FL, one year; medicine residency, LSU, Charity Hospital, New Orleans, 1968-69; elected by Singing River Medical Society.

SMITH, ANDREA L., Clarksdale. Born Memphis, Nov. 27, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned and medicine residency, Methodist Hospital, Memphis, 1980-83; elected by Clarksdale and Six Counties Medical Society.

TURNER, THOMAS A., Biloxi. Born Jackson, MS, Dec. 22, 1926; M.D., Tufts University, Boston, 1953; interned U.S. Naval Hospital, Bethesda, MD, one year; surgery residency, Orange Memorial Hospital, Orlando, FL, 1955-56; urology residency, same, 1963-64; elected by Coast Counties Medical Society.

ULMER, JACOB E., Carriere. Born Laurel, MS, May 19, 1956; M.D., University of Mississippi School of Medicine, Jackson, 1982; interned Self Memorial Hospital, Greenwood, SC, one year; family practice residency, University Medical Center, Jackson, MS, 1983-85; elected by Pearl River Medical Society.

WALCOTT, DEXTER W., Oxford. Born Greenville, MS, Dec. 20, 1954; M.D., University of Mississippi School of Medicine, Jackson, 1982; interned and pediatric residency, University Medical Center, Jackson, 1982-85; elected by North Mississippi Medical Society.

DEATHS

HILL, STANLEY A., Corinth. Born Aug. 22, 1907; M.D., University of Tennessee College of Medicine, Memphis, 1931; served an assistantship in orthopedic surgery to Dr. Guy Caldwell in Shreveport, LA; Past President of Mississippi State Medical Assn.; died May 23, 1986, age 78.

PENNINGTON, VERONICA, Jackson. Born Lansing, IA, June 11, 1895; M.D., Medical College of the State University of Iowa, 1919; interned Cincinnati General Hospital, Cincinnati, OH, one year; died June 7, 1986, age 91.

PRUITT, CHARLES, JR., Magee. Born Laneville, TX, Dec. 26, 1918; M.D., University of Texas Medical School, Galveston, 1941; interned Shreveport Charity Hospital, Shreveport, LA, one year; died May 16, 1986, age 67.

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PLACEMENT SERVICE

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STAFF PHYSICIAN: Full time, board certified general practitioner needed by progressive state mental retardation institution; small town in south Mississippi, 1½ hour drive to Gulf Coast. Attractive salary and fringe benefit package. Contact Personnel Department, Ellisville State School, Highway 11 South, Ellisville, MS 39437. We are an equal opportunity employer.

PEDIATRICIAN to join four man pediatric department in multispecialty group. Excellent salary and benefits leading to full partnership. Contact Jimmy E. Isbell, M.D., Rush Medical Group, P.A., 1800 12th St., Meridian, MS 39301 or call (601) 483-0011.

PHYSICIANS NEEDED

Physicians (especially specialists such as ophthalmologists, pediatricians, orthopedists, neurologists, etc.) interested in performing consultative evaluations (according to Social Security guidelines) should contact the Medical Relations Office. WATS 1-800-962-2230; Jackson, 922-6811; extensions 2275, 2276, 2249 or 2190.

The Mississippi Disability Determination Services now has a program available for medical society meetings and hospital staff meetings. The purpose of this program is to explain the Social Security Disability program, the medical documentation requirements, and how the disability determination process works. Any group interested in this presentation should also contact the Medical Relations Office.

EMERGENCY PHYSICIANS WANTED. Part-time and full-time positions. Columbus, MS. Call (601) 328-8385.

EMERGENCY ROOM physician needed to staff recently expanded emergency room coverage. Salary negotiable. Small town. 44-bed hospital approved for federal programs, located in central Mississippi. Contact Paul W. Strode, Box 428, Forest, MS 39074.

EMERGENCY MEDICINE and FAMILY MEDICINE positions available. Full-time positions available in hospital emergency departments and clinics. Prefer residency-trained or experienced physicians. Career opportunities available in central and south Mississippi. Attractive salary and benefit package. MEA, P.A. is a physician-owned and managed medical group committed to the financial security and personal development of each physician member. For information, contact: Sheila M. Lunceford; P.O. Box 12917, Jackson, MS 39236-2917; or call (601) 366-6503.

FAMILY MEDICINE positions available. Board certified or board eligible family physicians needed by largest multi-specialty group practice in state. Located 75 miles north of Mississippi Gulf Coast. Contact T. G. Thornton, Administrator, Hattiesburg Clinic, 415 South 287th Ave., Hattiesburg, MS 39401; (601) 268-5601.

MISSISSIPPI GULF COAST — Emergency Physician position available in Level II, medium volume ER. Two years experience or primary care specialty, ACLS required. Local ambulance service has ALS capability. Participation in EMS expected. Good recreational area, on the water, 65 miles east of New Orleans by Interstate. Contact David Sawyer, M.D., Box 209, Pass Christian, MS 39571; (601)865-1188 or (601)452-7581.

FAMILY MEDICINE positions available. Progressive rural community in south Mississippi has an immediate need for two physicians. Physicians will be employed by Jefferson Davis County Hospital and Extended Care Facility. Jefferson Davis County Hospital is a 41-bed acute care facility with a 60-bed long term care unit. Medical clinic under construction. For information contact Dale Saulters, P.O. Box 1289, Prentiss, MS 39474; or call 601-792-4276.

Physicians Available

PHYSICIAN COMPLETING MILITARY obligation seeks general practice location in south Mississippi area near Gulf Coast. Contact Paul Mumma, D.O., 3020 Rue Parc Fontaine, Apt. 1008, New Orleans, LA 70114.

RADIOLOGIST seeks private or hospital based clinical practice preferably emphasizing nuclear medicine. Graduate of U. of South Alabama Medical School, 1981. Contact Dr. H. T. Williams, 1663 Veteran Ave., Apt. 306, Los Angeles, CA 90024.

NEW ADDRESS

MSMA headquarters has moved to 236 East Capitol Street (third floor, Great Southern National Bank). Mailing address continues to be P.O. Box 5229, Jackson, MS 39216.

CLASSIFIED

RADIOLOGIC TECHNOLOGY program at Copiah-Lincoln Junior College graduates eight students August 1986. Information and references provided by Laura Williams, R.T., or Verna McFadden, R.T., Copiah-Lincoln Junior College, Wesson, MS 39191; phone (601) 643-5101, ext. 392.

MEDICAL OFFICE SPACE FOR LEASE. 4734 sq. ft., abundant parking, downtown area, 430 North Street, Jackson. For information phone (601)859-5251, Canton.

FOR SALE: Home in Eastover (''Doctors' Hollow''), Jackson; 4 bedroom, 3 + baths, living, dining, sunroom, patio, fireplace, large wooded lot, never flooded; $225,000 (under appraisal). Owner will finance with substantial down payment. Will consider nice townhouse in trade. Call (601) 366-2911 after 6:00 p.m.

Index to Advertisers

Automated Health Systems ..... **second cover**
Avanti 225

Bienville Center 228

Canton Exchange Bank 229
Curtis 1000 Information Systems **7**

Disability Determination Service 208

Glaxo/Roche **10A, 10B, 10C, 10D**

Harreld Chevrolet-Oldsmobile 226

Janssen Pharmaceutica 219

Eli Lilly and Company 230B

Miss. Baptist Medical Center **4**
Medical Assurance Co. of Miss. **8**
MSMA Benefit Plan and Trust 222

Premier Printing 226

Roche Laboratories ..... **third, fourth covers**

Smith Kline and French **6A**, 230A

The Upjohn Company **6A**
U. S. Air Force 214
U. S. Army Reserve **10**

John Wimbish **12**

Thomas Yates & Co. **6**



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"...onset of action is rapid...provides sleep with no rebound effect to agitate the patient the following day"

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Psychiatrist
California

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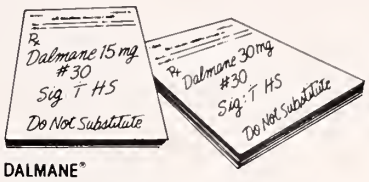
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References: **1.** Kales J, *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A, *et al. Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A, *et al. Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A, *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR. *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Dement WC, *et al: Behav Med*, pp 25-31, Oct 1978. **7.** Kales A, Kales JD. *J Clin Psychopharmacol 3*:140-150, Apr 1983. **8.** Tennant FS, *et al*: Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984. **9.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977



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Contraindications: Known hypersensitivity to flurazepam HCl, pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

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Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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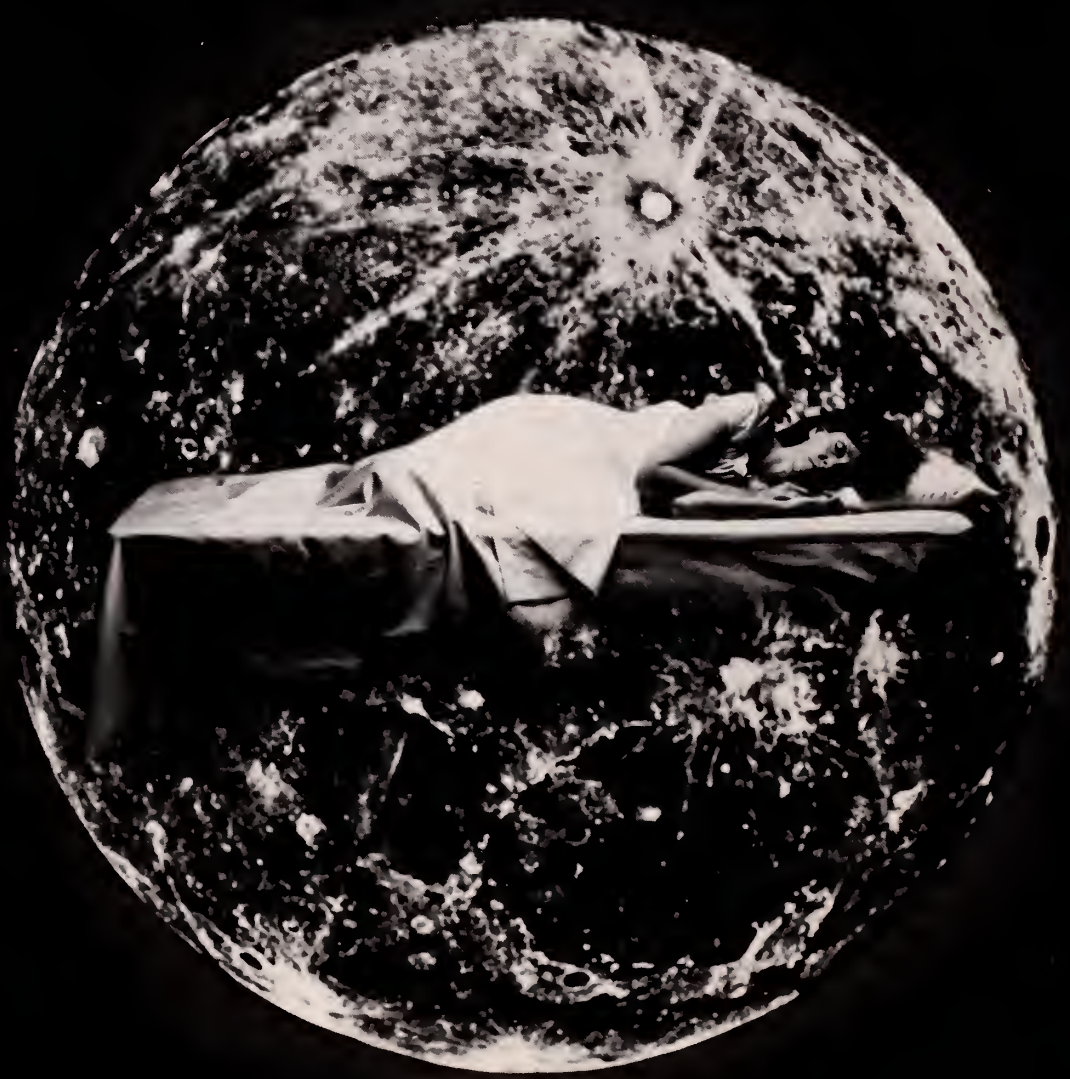
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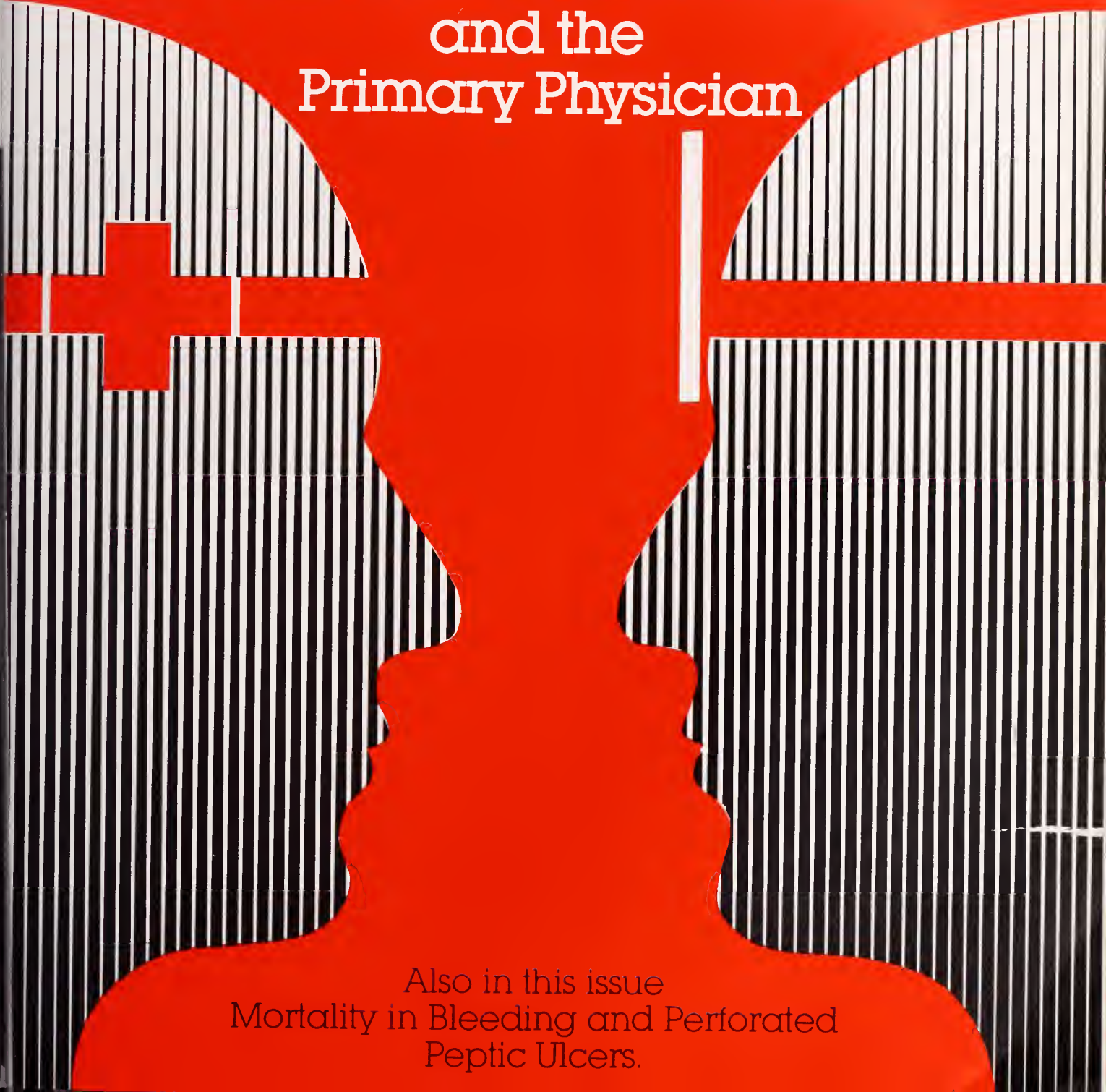
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September 1986

JOURNAL of the MISSISSIPPI State Medical Association

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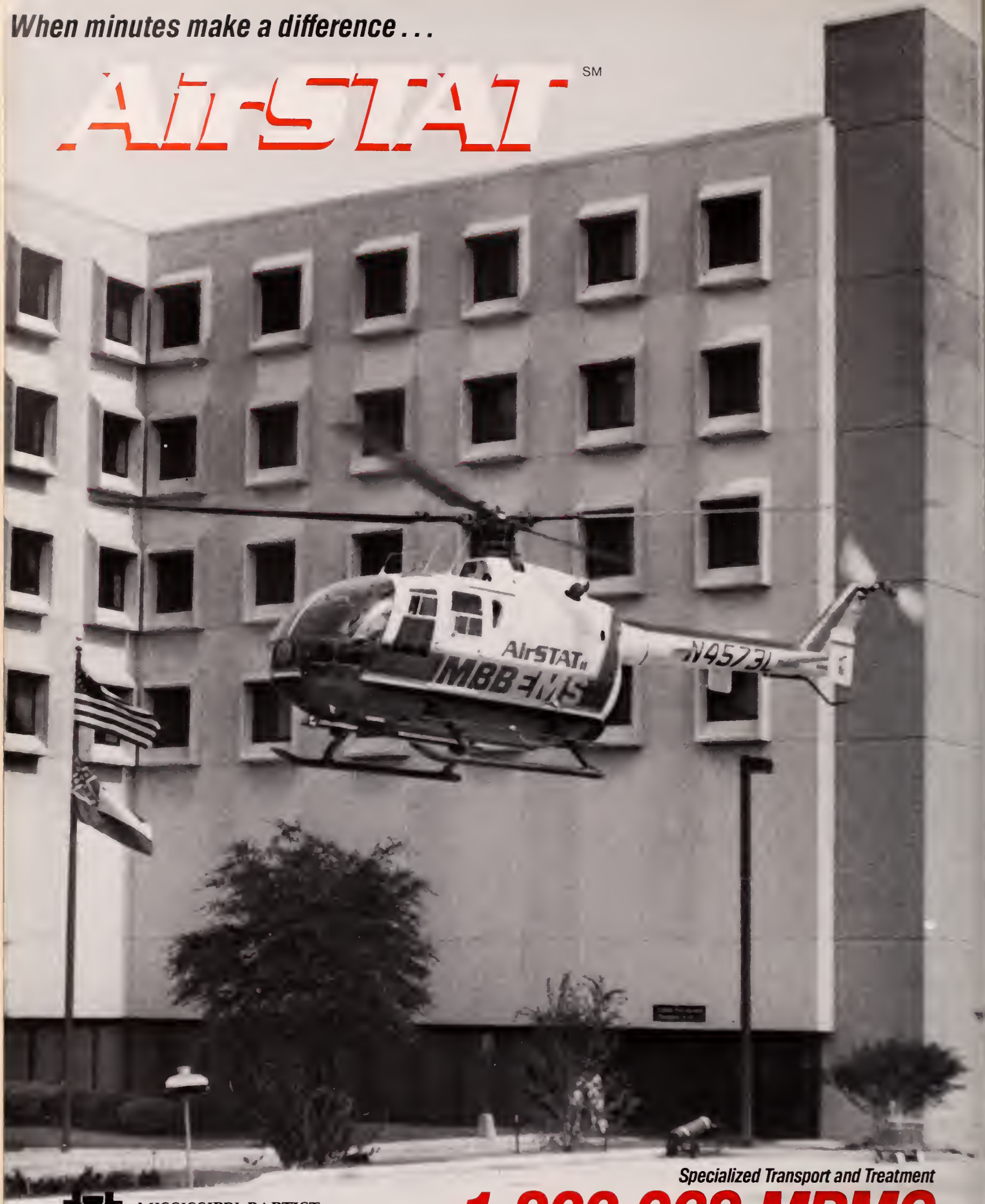
Craniocerebral Trauma and the Primary Physician



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Mortality in Bleeding and Perforated Peptic Ulcers.

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The Journal of the Mississippi State Medical Association is owned and published monthly by the Mississippi State Medical Association, founded 1856, at P.O. Box 5229, Jackson, Mississippi 39216. Subscription rate, $25.00 per annum; $35.00 per annum for foreign subscriptions; $2.25 per copy, as available. Advertising rates furnished on request. Printed by The Ovid Bell Press, Inc., Fulton, Missouri. Second-class postage paid at Jackson, Mississippi, and at additional mailing offices. POSTMASTER: Send address changes to Mississippi State Medical Association, P.O. Box 5229, Jackson, Mississippi 39216.

CONTENTS

ORIGINAL PAPERS

Craniocerebral Trauma and the Primary Physician **233** J. D. Miller, M.D. and R. R. Smith, M.D.

Mortality in Bleeding and Perforated Peptic Ulcer **237** Benton M. Hilbun, M.D., Jimmy L. Hamilton, M.D., Thomas K. Billups, M.D., and J. W. Williamson, M.D.

SPECIAL ARTICLE

Address of the President **241** Ralph L. Brock, M.D.

EDITORIAL

Bit by a What??? **245** Joseph E. Johnston, M.D.

Lawrence Long Will Be Missed **245** W. Moncure Dabney, M.D.

THIS MONTH

244 The President Speaking
245 Letters
247 Medical Organization
249 Deaths
251 Personals

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NEWSLETTER

September 1986

Dear Doctor:

The AMA's PRO Monitoring Project continues to solicit physicians' comments concerning experiences with peer review organizations. Since its inception in 1985 the AMA has received over 200 written communications representing the concerns of more than 5,000 individual physicians across the country. The comments have provided valuable insight into the problem areas encountered by both physicians and medical societies in their dealings with PROs.

> The AMA has a new Ad Hoc Committee on PRO, which will monitor developments in the PRO program, with particular attention focused on the impact of PRO operations on quality of care. Surveys of both medical societies and PROs will be undertaken to update the AMA's information base on PRO operations. And a PRO clearinghouse will be established and an educational program developed to inform practicing physicians about the PRO program in general and its relationship to the day-to-day practice of medicine in particular.

The number of services for the elderly offered by United States community hospitals will continue to grow in the immediate future, according to a survey of hospital services for the aging and chronically ill. More than 66% of community hospitals in the country have included in their long-range plans the development or expansion of services for the elderly, according to a survey by the American Hospital Association's Research and Educational Trust. Many of those hospitals have involved the community's elderly in the planning process.

Total spending for health care in the U. S. rose by 8.9% in 1985, the lowest rate of increase in two decades. But health care costs, which consumed a record 10.7% of the gross national product, still increased twice as fast as other prices. Health care expenditures totaled $425 billion last year, or about $1,271 per person, according to the Health Care Financing Administration (HCFA).

Sincerely,

Patsy Silver

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Managing Editor



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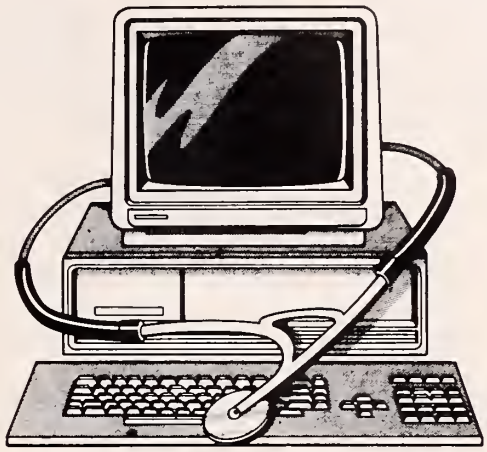
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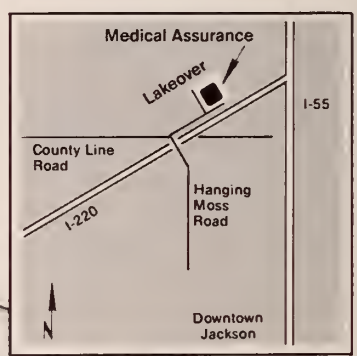
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DATELINE

Mississippi's First Lithotripters in Use

Jackson, MS - Mississippians who suffer from the third most common disease of the urinary tract, kidney stone disease, will soon have access to the latest non-invasive treatment technology. The state's first two Extracorporeal Shock Wave Lithotripters will be in operation by early next month at Jackson's St. Dominic Hospital and Hattiesburg's Forrest General Hospital.

MSMA Membership Benefits Available

Jackson, MS - Among benefits available to MSMA members is a new and expanded Group Purchase Program, which provides discounts on a broad range of medical and office supplies. Another benefit is the availability (at low cost) of HCFA-1500 Standard Forms, utilized by all third party payors in Mississippi. For information about either of these benefits, contact the MSMA headquarters office at 354-5433 (Jackson) or 1-800-682-6415 (WATS).

What Are Your Patients Thinking?

Jackson, MS - Another printing of patient survey forms has been ordered, and MSMA members may obtain a supply by calling the headquarters office. The patient survey is only one of several items in the Marketing/Communications Kit developed by the Council on Public Information. The kits also include tips on improving the patient/physician relationship and marketing your practice, along with various patient information brochures.

Elemental Diet May Reduce Radiation Injury

Chicago, IL - Feeding patients an elemental diet before, during, and after radiation treatment for bladder cancer may help prevent radiation injury, according to a report in the August Archives of Surgery. Patients in the study had much less damage to intestinal mucosa than is common after the procedure. An editorial comment called for additional studies, since intraoperative abdominal irradiation is becoming common.

CHAMPUS Will Become HMO System

Washington, DC - The Department of Defense plans, by late 1987, to place CHAMPUS in a health care delivery system with three regional contractors who will sub-contract with provider groups for medical services at pre-arranged prices. Under "Project Imprint" the "gatekeeper" role will be used to determine whether beneficiaries should receive care at military or civilian facilities.



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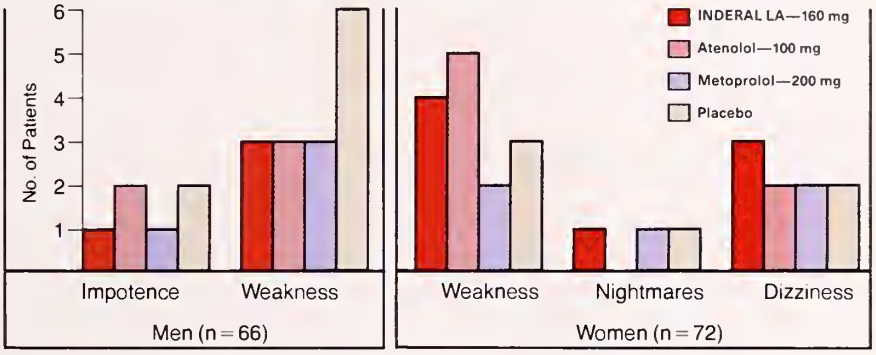
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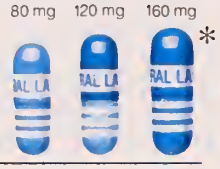
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CONTRAINDICATIONS

Propranolol hydrochloride (INDERAL® LA): Propranolol is contraindicated in: 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol.

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS

Propranolol hydrochloride (INDERAL® LA): CARDIAC FAILURE Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated, and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely; or propranolol should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction following *abrupt* discontinuance of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

MAJOR SURGERY The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution, since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS

Propranolol hydrochloride (INDERAL® LA): GENERAL Propranolol should be used with caution in patients with impaired hepatic or renal function. Propranolol is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that propranolol may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS Patients receiving catecholamine-depleting drugs, such as reserpine, should be closely observed if propranolol is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies, in both rats and mice, employing doses up to 150 mg/kg/day there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY Pregnancy Category C. Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose. There are no adequate and well-controlled studies in pregnant women. Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS Propranolol is excreted in human milk. Caution should be exercised when propranolol is administered to a nursing mother.

PEDIATRIC USE Safety and effectiveness in children have not been established.

Hydrochlorothiazide: GENERAL Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely: Hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs irrespective of cause are: Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect of digitalis (eg, increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content.

Any chloride deficit is generally mild and usually does not require specific treatment, except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism, such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

DRUG INTERACTIONS: Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

PREGNANCY Pregnancy Category C. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnancy requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

NURSING MOTHERS Thiazides appear in human milk. If use of the drug is deemed essential, the patient should stop nursing.

PEDIATRIC USE Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL® LA): Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia, congestive heart failure, intensification of AV block, hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability; slightly clouded sensorium; and decreased performance on neuropsychometrics.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

Hydrochlorothiazide:

Gastrointestinal: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation; jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis.

Central Nervous System: Dizziness, vertigo; paresthesias; headache; xanthopsia.

Hematologic: Leukopenia, agranulocytosis, thrombocytopenia; aplastic anemia.

Cardiovascular: Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity: Purpura, photosensitivity, rash, urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis); fever, respiratory distress, including pneumonitis, anaphylactic reactions.

Other: Hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
September 1986, XXVII, Number 9

ORIGINAL PAPERS

Craniocerebral Trauma and the Primary Physician

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Jackson, Mississippi

The local physician is usually the first to see and evaluate the head-injured patient. The authors describe measures for assessment of such patients. They note that prompt and proper neurosurgical consultation allows the best medical and/or surgical management of these patients, and can increase cost-effectiveness through prevention of avoidable and sometimes catastrophic complications.

THE HEAD TRAUMA victim often requires tertiary care; however, the initial care of such a patient and the decision for neurosurgical consultation is in the domain of the local physician. Certain clinical parameters can assist greatly in this decision. About two-thirds of the deaths from head injury occur prior to hospitalization, and in only about 10% of patients do acute management procedures determine eventual outcome.[5] Becker et al demonstrated that aggressive treatment of head-injured patients does not increase the numbers of severely disabled or vegetative patients, but such treatment did, in fact, enable some patients to have a good recovery who otherwise might have died.[1]

The extent of significant head trauma in Mississippi can be assessed by the following figures. From January 1, 1980 until June 30, 1985, there were 1177 patients admitted to the University Medical Center for intracranial injury (794 males and 383 females). One hundred and forty-three (12.15%) died, which compares favorably with the 10% incidence of fatality from head injuries estimated by Frankowski, Annegers, and Whitman from national statistics.[2] During the same interval 1308 patients were admitted to UMC with gunshot wounds, and of these, 119 had sustained gunshot wounds to the head (85 males and 34 females) with 29.4% mortality. There were 1710 patients admitted with a diagnosis of skull fracture (1307 males and 403 females), and of these, 97 (5.6%) died. Thus, our state has its share of craniocerebral trauma victims, and the local physician is often required to initiate care and determine the need for neurosurgical consultation.

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Neurosurgical Assessment

The most important parameter to evaluate in the head-injured patient is the level of consciousness. While such terms as lethargic, stuporous, comatose, and semi-comatose are commonly used, much more practical is use of a quantitive "coma scale." The Glascow coma scale has been widely accepted, and is based upon three simple examinations: eye-opening, motor response, and verbal performance, to derive a score between 3 and 15 (see Table 1).[4] A score of 15 is normal and 3 designates no response in the three areas tested. The best response of the patient obtainable should be used to determine the score. For instance, a patient with decorticate flexion in the upper extremities on one side and decer-

ebrate extensor posturing in the opposite arm and leg should be given a score of 3 for abnormal flexion as a motor response rather than a 2 for extensor response. A deficiency of such a scale is that an intubated patient obviously will have no verbal response, and this will consequently result in a lower score. The major benefits are that it allows several examiners to arrive at the same assessment of the patient, and it provides a quantitative method of evaluating the patient's progress. In general, if a patient has a coma scale of 12 or less, and remains at this level during his initial assessment and radiologic procedures, neurosurgical consultation should be obtained. Certainly, if neurologic deterioration is documented, neurosurgical consultation is urgently needed.

Focal deficits, most commonly a facial palsy, a dilated pupil, and/or a hemiparesis, should be considered secondary to an expanding mass lesion until proven otherwise. Hemiparesis in a patient with a decreased level of consciousness may be difficult to evaluate. However, often there will be more movement to painful stimuli on one side as compared to the other. Any focal deficit(s) following head injury warrants a neurosurgical evaluation.

Basilar skull fractures may be difficult or impossible to detect on radiologic studies, and must often be inferred from the physical examination.

Signs of a basilar skull fracture include periorbital ecchymosis with the ecchymosis sparing the supraorbital ridge (raccoon's eye), Battle's sign (ecchymosis over the mastoid, which may not appear until 24-36 hours following injury), cerebrospinal fluid rhinorrhea or otorrhea, and hemotympanum. While these patients usually do quite well neurologically, there are certain complications such as meningitis, traumatic intracranial aneurysms, and carotid-cavernous fistulae which can be formidable problems leading to morbidity and mortality. Suspected basilar skull fractures, in general, should be seen by a neurosurgeon.

Penetrating wounds of any type should be referred immediately following stabilization of vital signs. Gunshot wounds to the brain are best treated by immediate craniotomy in a potentially salvageable patient. During transfer, all wounds should be covered with a sterile bandage, and if there is significant scalp bleeding, a pressure bandage may be efficacious. Foreign objects protruding through the scalp should not be withdrawn prior to neurosurgical consultation.

The use of antibiotics in neurotrauma is controversial, and the decision to administer these is best individualized following conversation with the neurosurgeon who will be involved with the case.

TABLE 1

"GLASCOW" COMA SCALE

	Score
I. Eyes Open	
Spontaneously	4
To verbal command	3
To pain	2
No Response	1
II. Motor Response	
To Verbal Command Obeys	6
To Painful Stimulus Localizes pain	5
Flexion-Withdrawal	4
Flexion-Abmornal (Decorticate)	3
Extension (Decerebrate)	2
No Response	1
III. Verbal Response	
Oriented and converses	5
Disoriented and converses	4
Inappropriate words	3
Incomprehensible sounds	2
No Response	1
Total Score	3-15

Elevated intracranial pressure may occur early after head trauma. Hyperventilation and elevation of the patient's head if there is no cervical fracture should be instituted first to achieve the most rapid decrease in intracranial pressure. The use of dehydrating agents, such as mannitol, must be individualized. Certainly, any patient with documented, rapid neurologic deterioration is a candidate for such treatment. However, such patients should be referred urgently for neurosurgical care, and the decision to use mannitol should be made during conversation with the neurosurgeon. Steroid therapy has not been proven beneficial in head injury.[7] In fact, experimental data suggests that glucocorticoids may decrease neuronal ability to survive a variety of metabolic and ischemic insults.[6] Thus, the use of steroids is not indicated in head injury victims at the present time.

Radiologic Evaluation

The present role of routine skull x-rays following head injury is controversial. At least anteroposterior and lateral skull x-rays should be obtained if the patient has a decreased level of consciousness or any other deficit. However, the American College of Surgeons Committee on Trauma emphasizes that neurosurgical consultation or patient transfer should not be delayed by obtaining skull x-rays.[3]

Skull x-rays will document the presence or absence of a linear or depressed skull fracture, position of intracranial bullet and bone fragments, air/fluid levels in the sphenoid sinus (indicative of a basilar skull fracture), and pneumocephalus. Although linear skull fractures often heal, and the patient remains neurologically intact, linear fractures across the middle meningeal artery groove or in the posterior aspect of the skull should arouse suspicion of a possible epidural hematoma. Thus, such a patient should be watched closely, often under the care of a neurosurgeon. Patients with skull x-rays demonstrating depressed skull fractures, in which the outer table of the skull is driven beneath the inner table, evidence of basilar skull fracture, or foreign bodies inside the cranium should be under neurosurgical care. Any trauma patient with decreased consciousness of any etiology (head injury, alcohol, other drugs, etc.) should have a lateral cervical spine x-ray obtained early during the initial evaluation since cervical fractures may be easily overlooked.

Computed tomography (CT) has revolutionized the radiological evaluation of craniocerebal trauma. Patients with any type of neurologic deficit or decreased level of consciousness prolonged beyond a few minutes should have a cranial CT scan without contrast. This study will allow prompt detection of acute mass lesions and diffuse cerebral swelling. Commonly encountered lesions include subdural hematomas, epidural hematomas, and intracerebral hematomas and contusions. The presence of any of these lesions warrants neurosurgical consultation.

Summary

Head trauma occurs frequently in our state, and the local physician is usually the first to see and evaluate the head-injured patient. Assessment of level of consciousness by a coma scale, determination of focal deficits or presence of basilar skull fracture on physical examination, presence of fractures, sphenoid air/fluid levels, pneumocephalus, and presence of foreign bodies on skull x-rays, and intracranial masses or cerebral swelling on CT scan allow objective criteria to be used regarding the necessity of neurosurgical care. Prompt and proper neurosurgical consultation will allow the best medical and/or surgical management of these patients. This should also allow the most cost-effective method of dealing with these difficult patients by preventing avoidable and sometimes catastrophic complications. ★★★

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Mortality in Bleeding and Perforated Peptic Ulcer

BENTON M. HILBUN, M.D., JIMMY L. HAMILTON, M.D., THOMAS K. BILLUPS, M.D. and J. W. WILLIAMSON, M.D.
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In the review of 105 cases of bleeding and perforated peptic ulcer, the authors found a surprisingly high mortality rate of 17%. This is in contrast to the mortality rates that have been reported over the years. In most series this percentage has ranged from 6% to 12%. Their analysis suggests that the primary reason for this rising mortality rate in surgical treatment is the presence of co-morbid conditions. They maintain that it is apparent from this series that the availability and use of cimetidine has not decreased the number of cases requiring surgery for bleeding or perforation.

Approximately 10,000 Americans die each year from complications of peptic ulcer disease. Most of these deaths occur during the care of patients with bleeding or perforations.

The definitive management of these common complications of peptic ulcer disease, hemorrhage and perforation, has long been primarily the responsibility of the surgeon. Over the years the treatment protocol has been enhanced by the development and availability of newer medications, better surgical techniques, and more definite diagnostic procedures. In addition, a greater percentage of the surgical cases are being done by formally trained surgeons. In spite of this, we have experienced a progressive increase in mortality figures. The cases through the years 1975-1985 were reviewed retrospectively. We further analyzed these cases with respect to the emergence and widespread usage of cimetidine in the management of and prophylaxis for peptic ulcer disease.

Clinical Material

All cases of bleeding or perforated peptic ulcer over a ten year span 1975-1985 were reviewed. Only those cases that were treated surgically were included in the study. A total of 105 cases were placed in the analysis. Further, there was a total of 44 cases that required surgical intervention because of hemorrhage and a total of 61 cases operated on for perforation.

Discussion

In our series of 105 cases of surgically treated complications of peptic ulcer, 44 (41%) were for bleeding. The calculated operative mortality was 17%. Dronfield reported an operative mortality of 13%. The surgical procedure performed was either vagotomy-pyloroplasty and over-sewing or vagotomy with antrectomy. The selection of a procedure has remained rather constant over the ten-year span.

The incidence of bleeding ulcers requiring surgery had a modest increase over the last five years of the study (1980-1985). This would indicate to us that the use of cimetidine had no impact on the number of cases coming to surgery. Cartensen[2] reports a similar finding (see Table I and Table II).

Of the 105 total cases, 61 cases (58%) were perforations. In all instances the procedure of choice was simple closure. The overall mortality rate was 17.5%. Gray[3] reports a mortality of 13%. The average age of the patient was similar to that of the cases of bleeding, with an average of 58 years. The average age of the deaths was 71 years.

Again, as with the cases of bleeding ulcer, there seems to be no decrease in total cases after the introduction of cimetidine into the therapeutic reg-

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imen. McKay[4] reports a similar finding. He actually reported a modest decrease of 10% perforation, but a decline of 45% of cases requiring elective operations (see Table III and Table IV).

Why is operative mortality increasing? Are the patients older? Are we experiencing too long of a delay in proceeding with surgery? Are we doing the wrong operation? In attempting to answer these questions we have carefully analyzed our records and reviewed the experiences of others. Buckingham[5] reports no significant difference in the operative mortality of vagotomy-pyloroplasty versus vagotomy with resection. Buchman[6] addresses the question as to simple closure of the perforation versus a definite procedure. Again the cases must be individualized and therefore a firm grasp of the effect on overall mortality is difficult.

In our series of 105 patients it does not seem that age is an over-riding factor. True, the average age of the deaths was slightly higher, but not significantly. We believe the only valid explanation of a rising mortality rate in the surgical management of bleeding and perforated ulcers is the presence of various co-morbid conditions. We have experienced a large increase in the services of renal dialysis and oncology. In addition, the trauma service has become more active. A pulmonary service has been included in the last ten years also.

In reviewing the cases, we have found a persistent occurrence of various other systems involved. The more prevalent ones are respiratory failure, renal failure, immunosuppressed host, multi-system trauma and sepsis. Logan[7] reports a 47% occurrence of co-morbid illnesses in patients with bleeding peptic ulcers.

In addition, we find that often there is a significant delay in the transfer of patients from out-lying hospitals. In some of the patients that expired as a result of perforation, there was over a 48-hour delay in transfer. This is in contrast to the mortality rates that have been reported over the years. In most series this percentage has ranged from 6% to 12%. Our analysis suggests that the primary reason for

TABLE I

NORTH MISSISSIPPI MEDICAL CENTER —
PEPTIC ULCERS REQUIRING EMERGENCY SURGERY
FOR BLEEDING
1975-1979

Number of cases	18
Number of deaths	5
Mortality	(27%)
Procedures	
Vagotomy-pyloroplasty and oversewing	2
Vagotomy — subtotal gastrectomy	16
Average age	65
Average age deaths	55

TABLE II

NORTH MISSISSIPPI MEDICAL CENTER —
PEPTIC ULCERS REQUIRING EMERGENCY SURGERY
FOR BLEEDING
1980-1984

Number of cases	26
Number of deaths	2
Mortality	(7%)
Procedures	
Vagotomy-pyloroplasty and oversewing	9
Vagotomy-subtotal gastrectomy	17
Average age	60
Average age deaths	82

TABLE III

NORTH MISSISSIPPI MEDICAL CENTER —
PEPTIC ULCERS WITH PERFORATION
1975-1979

Number of cases	30
Number of deaths	3
Mortality	(10%)
Procedures	
Graham closure	30
Average age	65
Average age deaths	75

TABLE IV

NORTH MISSISSIPPI MEDICAL CENTER —
PEPTIC ULCERS WITH PERFORATION
1980-1984

Number of cases	31
Number of deaths	8
Mortality	(25%)
Procedures	
Subtotal gastrectomy	2
Graham closure	29
Average age	51
Average age deaths	68

this rising mortality rate in surgical treatment is the presence of co-morbid conditions. It is also apparent from this series that the availability and use of cimetidine has not decreased the number of cases requiring surgery for bleeding or perforation.

What might we do to stop this spiraling rise in operative mortality? It appears that we are dealing with sicker patients with multiple problems, and we will simply have to continue an aggressive approach to the peri-operative care utilizing all of the support areas available to us. We are doing the right operations. We are doing it at the appropriate time, and yes, we are doing it on older patients who have complicated problems in conjunction with peptic ulcer disease. ★★★

607 Garfield Street (38801)

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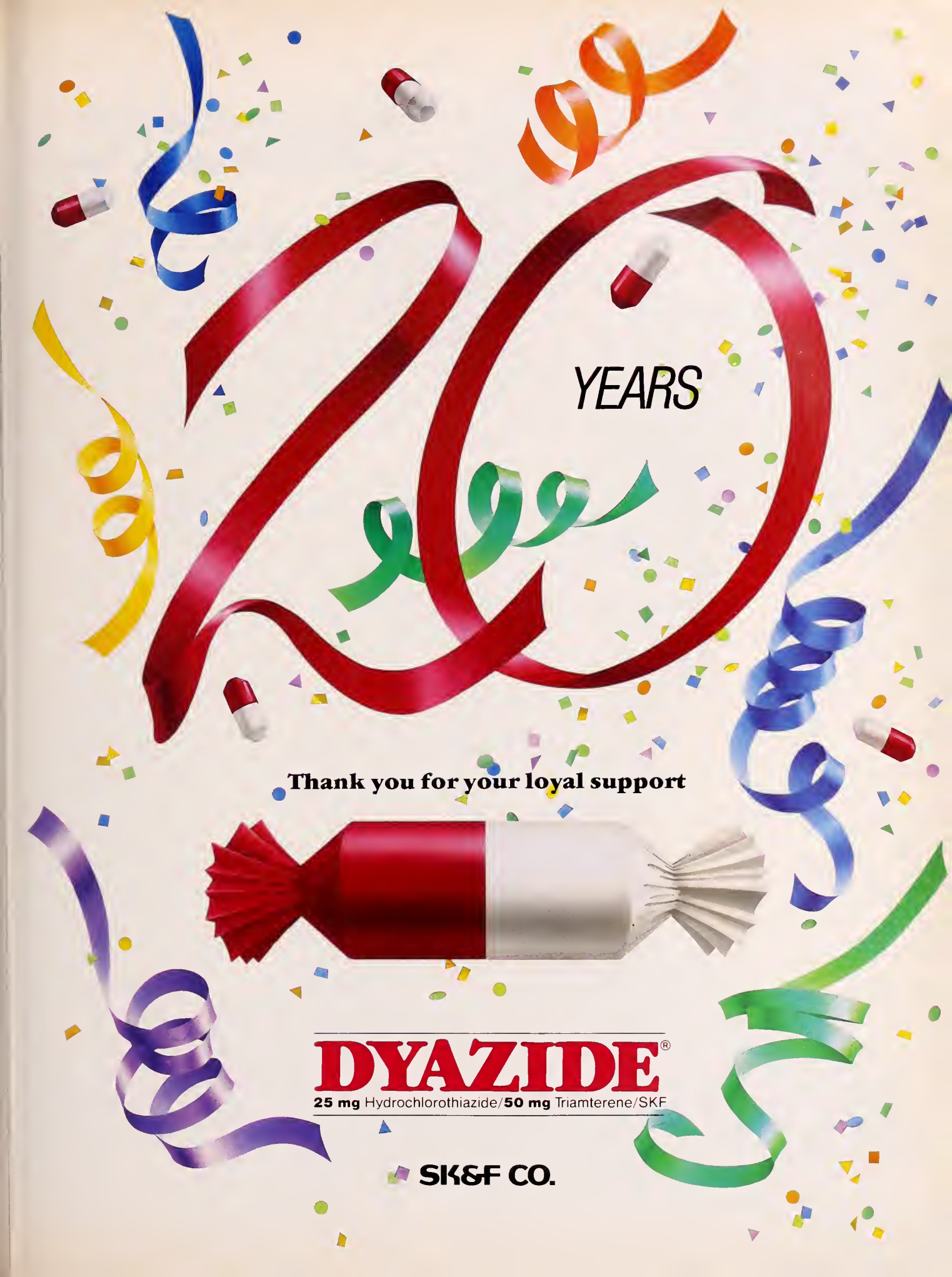
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There's never been a better time for her... and PREMARIN®

(Conjugated Estrogens Tablets)

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Significantly reduced risk of endometrial hyperplasia

Endometrial hyperplasia was significantly reduced when progestin was added to PREMARIN therapy for more than ten days a month.[1-4] The risk of endometrial hyperplasia may also be reduced through cyclic administration of unopposed, low-dose PREMARIN.

Effect on lipids—an important feature

PREMARIN used alone does not adversely affect lipid levels. In fact, a clinical study has shown a significant increase in HDL cholesterol—from 49.7 mg/dL to 56.4 mg/dL—and decrease in LDL cholesterol—from 165.1 mg/dL to 138.1 mg/dL—after one year of therapy with PREMARIN, 0.625 mg.[5]

Low-dose control of menopausal symptoms*

PREMARIN effectively relieves vasomotor symptoms, such as hot flashes. When estrogen deficiency is limited to atrophic vaginitis, PREMARIN® (conjugated estrogens) Vaginal Cream restores the vaginal environment to its premenopausal state.

The most widely used, most extensively studied estrogen worldwide.

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Most trusted for more reasons

*PREMARIN is indicated for moderate-to-severe vasomotor symptoms.

Please see following page for brief summary of prescribing information.

For moderate-to-severe vasomotor symptoms

PREMARIN®
(Conjugated Estrogens Tablets)



0.3 mg 0.625 mg 0.9 mg 1.25 mg 2.5 mg

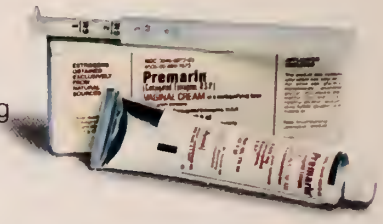
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For atrophic vaginitis

PREMARIN®
(Conjugated Estrogens)

Vaginal Cream

0.625mg/g



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)*

PREMARIN® Brand of conjugated estrogens tablets, USP
PREMARIN® Brand of conjugated estrogens Vaginal Cream in a nonliquefying base

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA

Three independent case control studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case control studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semiannual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equiestrogenic doses.

2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY

The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a non-steroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb reduction defects. One case control study estimated a 4.7-fold increased risk of limb reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe *vasomotor* symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) **Osteoporosis (abnormally low bone mass).** Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae. PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy. (See Boxed Warning.) 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. There are now reports that estrogens increase the risk of carcinoma of the endometrium in humans. (See Boxed Warning.) At the present time there is no satisfactory evidence that estrogens given to postmenopausal women increase the risk of cancer of the breast, although a recent study has raised this possibility. There is a need for caution in prescribing estrogens for women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Preexisting uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

a. Increased sulfobromophthalein retention.

b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.

c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG; free T4 concentration is unaltered.

d. Impaired glucose tolerance.

e. Decreased pregnanediol excretion.

f. Reduced response to metyrapone test.

g. Reduced serum folate concentration.

h. Increased serum triglyceride and phospholipid concentration. As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow, dysmenorrhea; premenstrual-like syndrome; amenorrhea during and after treatment; increase in size of uterine fibromyomata, vaginal candidiasis, change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss of scalp hair, hirsutism, steepening of corneal curvature, intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria; edema; changes in libido.

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females.

DOSAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only.* For treatment of moderate to severe *vasomotor* symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. *Given cyclically.* Female castration. Osteoporosis. Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Osteoporosis—0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off).

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only. For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three-to-six month intervals.

Usual dosage range: 2 to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

References:

1. Whitehead MI, Townsend PT, Pryse-Davies J, et al: Effects of estrogens and progestins on the biochemistry and morphology of the postmenopausal endometrium. *N Engl J Med* 1981;305:1599-1605. **2.** Paterson MEL, Wade-Evans T, Sturdee DW, et al: Endometrial disease after treatment with oestrogens and progestogens in the climacteric. *Br Med J* 1980;280:822-824. **3.** Magos AL, Brincat M, Studd JWW, et al: Amenorrhea and endometrial atrophy with continuous oral estrogen and progestogen therapy in postmenopausal women. *Obstet Gynecol* 1985;67:496-499. **4.** Whitehead MI, Lane G, Siddle N, et al: Avoidance of endometrial hyperstimulation in estrogen-treated postmenopausal women. *Semin Reprod Endocrinol* 1983;1:1:41-52. **5.** Barnes RB, Roy S, Lobo RA: Comparison of lipid and androgen levels after conjugated estrogen or depo-medroxyprogesterone acetate treatment in postmenopausal women. *Obstet Gynecol* 1985;66:216-219.

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SPECIAL ARTICLE

Address of the President

RALPH L. BROCK, M.D.
McComb, Mississippi

A PLEA FOR UNITY is nothing new. The history of this country is full of it and "United" is the first word in our nation's name. One year ago one of the leading issues debated in our House of Delegates was the proposal of unification with the AMA. I am pleased that the vote was overwhelming in favor, and now I can report to you that the members accepted this recommendation with a great response.

On April 1 of last year (our dues delinquency date) we had a total membership of 2,141 members and 75 percent of those belonged to the AMA. This year on that same date we had 2,171 members and 100 percent belonged to the AMA.

In his president's address last year, Dr. Moffitt expressed a goal to have at least 85 percent of the practicing physicians in the state belong to MSMA. We now have 84 percent. You who are here today make up the largest gathering of our members we will have at one time. I appreciate your presence, but we represent only about 20 percent of our membership. The other 80 percent are back home.

It has been discussed frequently as to the most effective way to communicate with the membership. Political candidates rely heavily on television, but that is not practical for us. Direct mailing reaches everyone, but too many fail to read it. I think most of us agree that personal contact between people that know each other is best. This is what I am asking you to do.

Some of you may feel that having most of the practicing physicians in the state is enough. Don't worry about the others. I feel that we need them and they need us.

I am even more concerned about the 80 percent of our members that are not here today. It may be like a minister preaching to the choir, but if I can solicit your help, I would like to accomplish two things:

(1) Give all our physicians a sense of belonging and,

(2) Make them aware of pertinent issues that affect all of us.

I want you to go back home and talk to your colleagues — whether they practice in a university setting, a large tertiary referral center, medium or small hospital, group practice, or solo in a rural setting. I want you to convey this message — that we have common problems and desires. We need to stick together and feel that sense of belonging to an organization that is trying, and willing, to fight for what is best for our profession. We need to respect those differences that separate us and concentrate on the many things that we have in common.

We all need to be aware of pressing issues that will influence our practices for the next decade. I ask you to study these and carry this knowledge back home and spread it among your fellow physicians.

I would like to discuss just a few of these issues with you this morning: (1) the supply of physicians; (2) access to care; (3) medical education; (4) quality and financing of health care.

Supply of Physicians

We are well aware of the successful effort to produce more medical graduates during the past 15 years, but these same efforts failed to address adequately geographic distribution and proper balance between primary care and sub-specialty practice. Mississippi is a good example of poor distribution

Presented at the 118th Annual Session, June 5, 1986, in Biloxi, MS. Dr. Brock is MSMA's immediate past president.

of physicians in certain areas. Federal programs have been partially successful for short periods of time, but we need to get less dependent on federal funds. We need to go back to the time when our problems were the responsibility of the family, church or local community. I recommend that MSMA take a more active role in serving as a liaison between physicians and communities in getting someone to locate in areas that do not have a doctor. It is likely that a pair of physicians would agree to set up practice. MSMA could help get concessions from the community in the way of the office space, assist in office management, and assure readily available consultation through surrounding hospitals and specialists.

Access to Care

One of the most important social issues in the next decade is whether access to care will be limited by the ability to pay.

For the medical profession, withholding care is clearly an unacceptable choice. Surely the best possible care delivered in the most humane fashion has a higher priority than the degree of reimbursement. Payment should not affect the quality of care we give. We need to remain our patient's advocate and be the concerned, compassionate, and caring physician.

Let me give you a short illustration: The fourth in a series of medical specialists has just finished examining this elderly gentleman that had a puzzling problem. The patient called the last examiner to his bedside and said: "I appreciate what each of you are trying to do for me. I realize you are all well trained in your field, and I respect your scientific knowledge, but I want a doctor!"

Let me suggest to you some things I have found helpful in my practice:

(1) When you make rounds, make a point to sit down in the patient's room, indicating that you are not in a hurry. This is easier and less awkward if you make rounds alone. This may be your best opportunity to get the patient to confide in you and tell something that has been held back.

(2) Try taking the blood pressure on each of your office patients. This forces you to sit down, slow down, and touch the patient.

(3) Write out your prescriptions — preferably in front of the patient. Patients look on this as one of the most personal services that you perform for them.

Physicians will have a role in decisions relating to access to newer and expensive technologies such as artificial hearts and heart transplants. Our affiliation with the AMA will serve us well here. We need to offer our ideas, but we need the broadest base of the best medical minds available to help solve these problems.

Medical Education

We must not forget that the entire medical system depends on the generation and dissemination of new knowledge. Our medical and research centers are threatened by loss of stability in funding. If this is not corrected, many important steps will be lost in producing our ultimate goal: the prevention of disease.

This is another place we need to lead the way in getting our training programs and research projects less dependent on federal funds. We need to increase efforts in stimulating all medical graduates to be regular supporters of their schools. The AMA-ERF Fund is great, but that, and more like it, need to be expanded.

One of the greatest challenges to our medical schools, as newer technology evolves, is maintaining the proper balance between basic science and clinical departments. MSMA and our medical school have had a good relationship through the years. This should not be taken for granted, but active efforts should continue to maintain regular communication and assurance of cooperation with administration, staff, and students.

Quality and Financing Health Care

I have been very excited over the proposal and response of our members to the statewide HMO/IPA. In my opinion that is the most significant thing we could do to help stabilize the many methods of health care delivery being offered. This should go a long way toward preserving the doctor-patient relationship and making it possible to provide quality medical care at a reasonable cost.

I want to solicit your assistance in carrying the word to your colleagues back home. Even if the HMO/IPA develops rapidly and is very successful, it is very likely that the solo practitioner in the remote areas will realize benefits much slower than physicians in larger cities. Assure them that everyone is important. We want everyone to participate as much as possible and we want everyone to have that sense of belonging.

A lot has happened this past year, and I expect the next few years to be even busier. We are going to need the finest leaders possible and we need to be developing new ones. I would like for you to give thoughtful consideration to a resolution in your delegate's handbook suggesting a way to get more of our members to attend the AMA Leadership Conference. This is an excellent meeting each year in

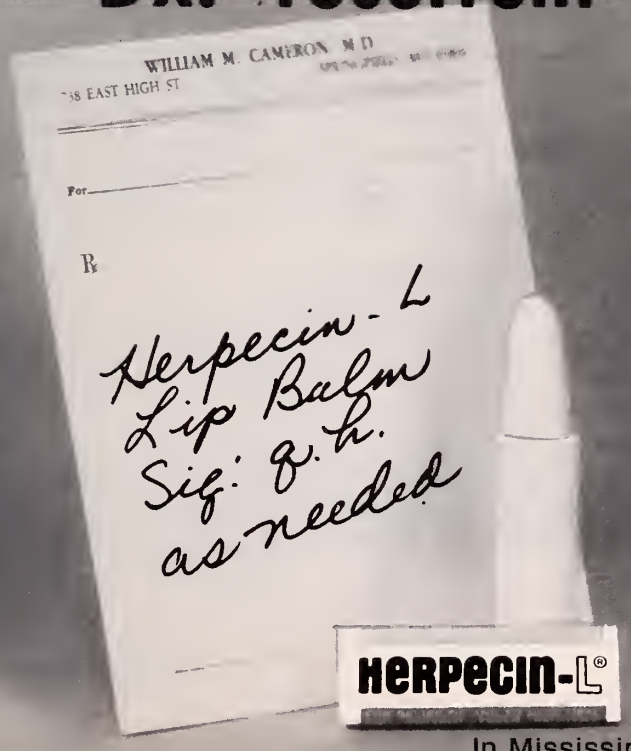
February. If each component society would send one person — perhaps their president-elect, MSMA is being asked to share the expense. I think this is a good way to stimulate interest throughout the state and help identify our future leaders.

Dr. Rogers, in your speech at the AMA Interim Meeting last December, you expressed a hope that you wanted to counter negative attitudes developing among physicians over many of the things I have talked about today. I hope that during your visit with us that you will see that the Mississippi State Medical Association does not have its head in the sand, and we are not going around with long faces. We agree with you that the future of medicine is bright and we are pleased to be one of the new unified states with AMA. We will stand shoulder to shoulder with you as you lead us toward this bright future.

Now, I want to say a special "Thank You" to all of the headquarters staff. I have spoken to each of them and will not call them by name today. The board and general officers know, but I want the membership at large to be reminded that this is a group of dedicated people putting out 150 percent effort every day in our behalf.

How do you thank someone for the honor and opportunities you have given me as your president this past year? I cannot find the words to express my true feelings. I do want you to know that Billie and I appreciate the many courtesies shown to both of us. We look forward to many years of enjoying the lasting friendships that were developed and started this year. Thank you very much! ★★★

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The President Speaking

Your Involvement Necessary for Tort Reform

W. JOSEPH H. BURNETT, M.D.
Oxford, Mississippi

I'm confident tort reform in Mississippi is foremost in your minds this year. Therefore, I'll be discussing this subject now and again. Also, I will be discussing the need for everyone's involvement.

There's much more to this subject than just changes in the tort reform system to hopefully benefit physicians and the medical malpractice crisis. Our legal system has served us well for many years, and none with whom I've discussed this subject would like to see an individual's right to recover damages repealed, regardless of whether a medical malpractice or civil suit is involved.

I am serving on an ad hoc committee of your board to meet with representatives from the Mississippi Trial Lawyers Association. We hope that by the time this goes to press we will have had our second meeting and will be continuing efforts to explore problems on both sides of this issue.

As you likely know, 23 states okayed reforms in 1986. These involve caps on non-economic damages and caps on overall general damages in two states. But are you also aware that of 23 states passing tort reform, 19 also imposed new requirements on insurance companies? Most of these requirements added provisions for reporting of insurance company finances or placed time restrictions on companies' ability to cancel or non-renew a policy. Also, some states modified their laws on joint and several liability, thus providing some protection for the "deep pocket" defendant.

There is indeed more to the issue of tort reforms than just caps, etc. Not only is there need to control unreasonable jury awards, but the insurance industry must also conduct its business more responsibly and keep the public's as well as stockholders' interests in mind.

I hope you will be learning of progress in this area in the near future. Keep in mind there's more to this subject than some of you may realize. You must be informed, supportive, and involved in this issue for effective changes to be accomplished.

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XXVII, Number 9

SEPTEMBER 1986

Bit by a What???

As I have said before, "If you stay in family practice long enough you will see one of every kind of medical problem." I was sitting in my office doing chart work recently when the telephone rang and the voice at the other end excitedly said for me to come to the emergency room at once — that they had a lady who had been bit by a lion.

When I arrived, I found the arm to have been chewed up pretty badly, and I proceeded to send her to one of those nice people who treat lion bites of the *right* hand. When I got this specialist on the telephone, his first words were, "Bit by a What?" Now, Joe, I knew you practiced way out in the country, but not *that* far!"

Well, anyway, when I asked the lady how the accident happened, she related to me that down at the local animal park the woman who managed it told her to go ahead and pet the lion — that it would be okay. So she did, and so she got bit.

This reminds me that daily, we, too, are bit by the "Lion." Under the guise of "it won't bite you" or our old familiar, "If we don't do it for ourselves, the government will do it for us," we are suckered in, only to find that we have been harangued, heckled, and harassed by the nice old lion called "Government." Yes, he means well, maybe, but the end result is just as though we had put our heads and those of our patients into the lion's mouth.

Thank God I am a physician — in this Animal Kingdom.

JOSEPH E. JOHNSTON, M.D.
Associate Editor

The editors invite your comments, inquiries, and suggestions. Please address letters to the Editors, *Journal of the Mississippi State Medical Association*, P.O. Box 5229, Jackson, MS 39216.

Lawrence Long Will Be Missed

His booming voice will be missed.

Every member of our state medical association will be aware of his absence when they enter and leave the lobby of the convention hotel next year. His loud voice and his sometimes off-color, but never offensive, remarks won't be heard again, and few will not be conscious of this.

The casual observer might have been fooled by his manner of speech and his occasional excesses, but he was a man of great integrity, compassion, and ability; and he was a student. Although he never boasted about it, he was justifiably proud of his Phi Beta Kappa key. His many achievements and awards have been listed in his obituary and need not be repeated here.

He was single-handedly responsible for bringing *The Mississippi Doctor* from Booneville in 1959, and with Roland Kennedy, our Executive Secretary at the time, for beginning our *Journal of the Mississippi State Association* that we have today. Probably no man has contributed more to organized medicine in Mississippi than he.

Lawrence Long will be missed, and the annual convention will be less colorful in his absence.

W. MONCURE DABNEY, M.D.
Editor Emeritus

LETTERS

SIRS:

The subject that Dr. Johnston chose for his editorial ("High Tech in Rural Mississippi" — July issue) was indeed timely as evident from his statistics indicating that the number of practitioners doing in-office laboratory procedures has increased greatly over the past years.

There is little doubt about the benefits of having

readily available laboratory tests in one's office. With this should come as suggested, some sort of quality assurance program; any move in this direction will be in the best interest of the patient, the physician, and those government agencies who are looking at the growth in this practice with concern and no doubt a degree of skepticism.

The issues which have not been addressed are, I think, more relevant and center around the appropriateness of tests that are ordered in a physician's office and the overall cost of this on the healthcare system. There is little doubt that this is a classic setup for a conflict of interest situation where physicians can become very dependent on money generated by laboratory procedures in order to supplement their income. As various government agencies find ways to decrease remuneration for physician's traditional services (ie, to diagnose and manage patient's problems), a logical reaction could well be the further expansion of office ancillary facilities.

I believe that we are at great risk relying on office laboratory procedures as the means of supplementing our income in the practice of medicine. We really should be addressing the issues brought forth by the American Society of Internal Medicine where we physicians should be more adequately compensated for utilizing our cognitive skills. This emphasis on cognitive skills is essential if we are to be remunerated in an appropriate fashion for what we have been trained to do. We have not been trained to run office labs.

My impression is that physicians in general, particularly primary care physicians are underpaid for these time-consuming activities of general assessment and followup of patients. Physicians in other countries have learned this lesson and are remunerated much more realistically for these skills. They also have found that government over a period of time finds reasons to do away with office laboratory facilities.

William C. Nicholas, M.D.
Jackson, MS

To The Editors:

Thank you for publishing in your journal the article written by Dr. G. Rodney Meeks and myself entitled "The Physician's Role in Rape Victim Management: An Examination of Rape Epidemiology in Mississippi" (August, 1985). In addition, an abstract of that article appeared in the journal, *Sexual Coercion and Assault*. Statistics concerning rape cases in central Mississippi were reported by me as information obtained from the Mississippi Rape Crisis Center. However, the statistical information pertained only to rape cases in the Jackson, Mississippi area as collected by the Rape Crisis Center.

We appreciate the help that the director of the Rape Crisis Center, Ms. Maxine Lyles, has given us in compiling the above report. Please assist us in clarifying to your readers that the statistics we reported were collected in the Jackson, Mississippi area only and did not reflect statewide data.

Darden H. North, M.D.
Jackson, MS

To The Editors:

I sincerely appreciate and concur with the accolades given to our delegation to the American Medical Association (July issue). I am very proud of these individuals and for the hard work and contribution of their time, energy and money expended on our behalf. However, there are two delegates who were not mentioned who do deserve as much praise as our own special delegation. These are Dr. Faser Triplett, who represents the American College of Allergists, and Dr. Raymond Grenfield, Sr., who represents the American Society for Clinical Pharmacology and Therapeutics. These two gentlemen do meet with the Mississippi delegation and help share some of the Reference Committee responsibilities. They also sit with our delegation in the House of Delegates. I feel they are as deserving in praise as our own delegation.

Ellis M. Moffitt, M.D.
Jackson, MS

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New Staff and Department Announced

Long-time and recently retired Ole Miss Medical Alumni Secretary, Bill Price, will join MSMA's staff this month as director of a new Department of Practice Management and Specialty Society Services.

Based on recommendation by MSMA Executive Director, Charlie Mathews, and approval of the Board of Trustees at its recent summer meeting, Price will staff a new Medical Payment Systems program to be jointly sponsored in Mississippi by MSMA and the American Medical Association. He will also assume responsibility for specialty society administrative services furnished by MSMA to a growing list of state specialty organizations.

Price recently retired as Ole Miss Medical Alumni Secretary after serving in that post for 26 years. He is a native of Columbus, Mississippi and a graduate of Ole Miss.

Medical Payment Services (MPS) will be announced to MSMA members this month. It is a national electronic billing system being jointly sponsored by the AMA, MPS and selected medical societies. MSMA is one of the first medical societies selected to offer the system.



Bill Price, former secretary of the University of Mississippi Medical Alumni Chapter, joins the MSMA staff this month as director of a new Department of Practice Management and Specialty Society Services.

Funeral Services Held For Dr. Lawrence Long

Dr. Lawrence W. Long, 84, of Jackson, died July 10 at King's Daughters Hospital in Yazoo City. Services were held in Yazoo City with burial in the family cemetery on Churchill Plantation near Sartartia.

Dr. Long, a past president of the MSMA, had retired from practice last year. He was instrumental in obtaining *The Mississippi Doctor* from a physician publisher in Booneville in 1959 and establishing the publication as the *Journal of the Mississippi State Medical Association*, first published in 1960. He had served as chairman of the Publications Committee for more than 25 years.

A native of Jackson, Dr. Long attended Millsaps College and graduated from Vanderbilt University in 1923 with a master's degree. He received the M.D. degree from the Vanderbilt Medical School in 1927. He served his internship at Vanderbilt University Hospital and completed residencies at Charity Hospital in New Orleans and Charity Hospital in Jackson. He had served as chief of staff of the Mississippi Baptist Medical Center in 1936, and in addition to serving as president of the MSMA, was also president of Central Medical Society.

Dr. Long was a senior fellow of the Southeastern Surgical Congress. He was a member of the Mississippi State Board of Health from 1942 to 1948. He was a life member of the American College of Surgeons, and treasurer of the International College of Surgeons. He received the meritorious service award presented by the United States Section of the International College of Surgeons. He was a member of Alpha Omega Alpha and Kappa Alpha Order.

Dr. Long served in the Tennessee National Guard in World War II and was later director of Selective Service for Mississippi. He retired from the Mississippi National Guard with the rank of brigadier general, and was awarded the Distinguished Service Medal by Gen. Louis Hershey.

He is survived by his wife, Mrs. Anne Wright Long, son, Lawrence W. Long, III of Yazoo City, daughter, Mrs. Cornelia L. Matson of Osprey, Florida, six grandchildren and three great-grandchildren.

UMC Announces Faculty Appointments

Six have been appointed to the University of Mississippi Medical Center faculty for the new academic session.

Dr. Norman C. Nelson, UMC vice chancellor for health affairs, made the announcement following approval by the Board of Trustees of State Institutions of Higher Learning.

In the School of Medicine, Dr. Phillip R. Godding and Dr. Thomas J. Payne were named instructors in psychiatry and human behavior (psychology). Donald B. Penzien was named assistant professor of psychiatry and human behavior (psychology), and Dr. Harry W. Severance, Jr., assistant professor of medicine.

Dr. Leon Anderson II was named instructor in restorative dentistry in the dental school, and in the School of Nursing, Helene A. Rasberry Jones was appointed assistant professor of nursing.

Dr. Godding attended Evangel College and earned the B.S. in 1979 at the University of Minnesota. He earned the M.S. in 1982 at North Dakota State University and the Ph.D. in 1986 at Florida State University. He did his residency at UMC.

Dr. Payne earned the B.A. in 1975 at the State University of New York at Oneonta, the M.A. in 1979 at Fairleigh Dickinson University at Rutherford, New Jersey, and the Ph.D. in 1986 at State University of New York at Binghamton. He completed his residency at UMC.

Penzien earned the A.B. degree in 1979 at Hope College, and the M.S. in 1982 at Ohio University. He was a health psychology trainee in 1985 at the Stress and Health Clinic of Ohio University and did his internship at Brown University Clinical Psychology Internship Consortium. He is a candidate for the Ph.D. in August at Ohio University.

Dr. Severance earned the A.B. degree in 1970 at Duke University, the B.A. in 1976 at East Carolina University and the M.D. in 1981 at Duke University Medical Center, and did his residency at East Carolina University School of Medicine and Pitt County Memorial Hospital. He has been on the medical staff of Wilson Clinic in Wilson, North Carolina since 1983, and was in program management at Duke University from 1970-1973.

Dr. Anderson received the B.S. Ed. in 1974 and the M.S.T. in 1977 from Jackson State University. He earned the D.M.D. degree in 1985 at UMC, where he completed a dental residency prior to his faculty appointment. He was in the U.S. Air Force from 1966-1970, an instructor in biology with the Jackson Public School System from 1974-1981 and field coordinator from 1979-1981, and has worked as a laboratory technician and research technician in the dental school.

Ms. Jones received the B.S.N. in 1962 from Oklahoma Baptist University in Shawnee, Oklahoma, and the M.S. in nursing in 1970 from Emory University. She has been on the nursing staff at Selma Baptist Hospital in Selma, Alabama, Presbyterian Hospital and Wesley Hospital in Oklahoma City, Oklahoma, and Walter Reed General Hospital in Washington, D.C. She has been instructor in nursing at Baptist Memorial Hospital School of Nursing in Oklahoma City, and William Rufus King State Technical Institute at Selma; and, at the UMC School of Nursing, she was assistant professor from 1970-1973, associate professor of nursing from 1973-74, and professor from 1974-1980. She was associate professor of nursing from 1980-1981 at the University of Tulsa College of Nursing, then joined the staff of the Hillcrest Medical Center in Tulsa as coordinator of orientation and staff development from 1983-1986, when she was named assistant director of nursing.

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MSMA Delegation Meets with AMA Executive Committee



Members of the Unified Societies Advisory Committee met with the Executive Committee of the AMA Board of Trustees during the 1986 Annual Meeting in Chicago. From left are: Dr. Lamar Weems, an MSMA delegate to the AMA; Dr. Joseph T. Painter, member of the AMA Board of Trustees; Charles Mathews, MSMA executive director; Dr. W. Joseph Burnett, MSMA president; Dr. John Coury, Jr., then president-elect of the AMA; and Dr. Harrison Rogers, then AMA president.



Correction: One of the winners in the 118th Annual Session's Fishing Rodeo was incorrectly identified in the July issue. Pictured above is Ayers Spencer, Jr., son of Dr. and Mrs. William A. Spencer of Sardis, with his prize-winning Jackfish.

DEATHS

HOWORTH, BECKETT, Jackson. Born Aug. 11, 1902; M.D., Washington University School of Medicine, St. Louis, MO, 1925; interned, one year, Presbyterian Hospital, New York City, NY; surgery residency, same, two years; orthopedic surgery residency, New York Orthopedic Hospital, NY, three years; medical sciences degree, Columbia University, NY, 1934; died July 16, 1986, age 83.

POWELL, JOE, Poplarville. Born Feb. 16, 1916; M.D., Louisiana State University School of Medicine, New Orleans, 1952; interned Charity Hospital, New Orleans, one year; died July 22, 1986, age 70.

TURNER, LUTHER D., Crystal Springs. Born July 20, 1920; M.D., Louisiana State University School of Medicine, New Orleans, 1951; interned Mercy Hospital and Street Clinic, Vicksburg, MS one year; died Aug. 9, 1986, age 66.



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PERSONALS

THOMAS F. ADAMS has associated with JESSE C. WILLIAMS and PERRY WALLACE for the practice of internal medicine and pediatrics at 2104 5th Street North in Columbus.

TIM ALFORD has associated with Attala Medical Clinic, 314 West Adams Street, Kosciusko, for the practice of family medicine.

ORLANDO ANDY of UMC presented a paper at a meeting of the Association of Professional Sleep Societies in Columbus, Ohio.

EDWARD J. BASS of Hattiesburg announces the association of KURT F. BRUCKMEIER for the practice of internal medicine.

BLAIR BATSON of UMC chaired a meeting of the governmental affairs committee of the American Academy of Pediatrics in Washington, DC.

MARY KATHRYN BOWEN announces the opening of her practice of pediatric neurology and general pediatrics at 115 Sharkey Avenue in Clarksdale.

LEONARD H. BRANDON of Starkville recently was installed as president of the Mississippi Academy of Family Physicians.

E. E. BRAMLITT and BRUCE BULLWINKEL announce the opening of their office for the practice of general surgery, gynecological surgery, thoracic and vascular surgery at 716 South Main Street in Ripley.

ARNOLD D. BRIDGES, JR. announces the opening of his office for the practice of internal medicine at 965 Avent Drive, Suite 105, Grenada.

JOHN D. BURK of Tupelo was chairperson for Mississippi's delegation to the 46th Annual meeting of the American Diabetes Association in Anaheim, California.

GEORGE W. BYRNE of Pass Christian announces his retirement from the practice of general surgery.

MICHAEL J. CIRILLI has associated with LEON LENOIR and ROBERT LEE of Greenville for the practice of internal medicine.

SAMUEL N. CROSBY has associated with the Hattiesburg Clinic for the practice of family medicine.

D. RANDALL CURRIE announces the opening of his office for the practice of pulmonary medicine at 150 Jefferson Davis Boulevard in Natchez.

ALTON H. DAUTERIVE announces the opening of his office for the practice of peripheral vascular surgery at 1245 Broad Avenue in Gulfport.

PATRICIA DUDLEY has associated with Neuropsychiatry and Psychology Associates and Laurelwood Psychiatric and Recovery Center in Meridian for the practice of psychiatry.

DAVID L. EAKES has associated with Columbus Children's Clinic for the practice of pediatrics.

BEN P. FOLK, III, announces the opening of his office for the practice of cardiology at 1705 Hospital Street in Greenville.

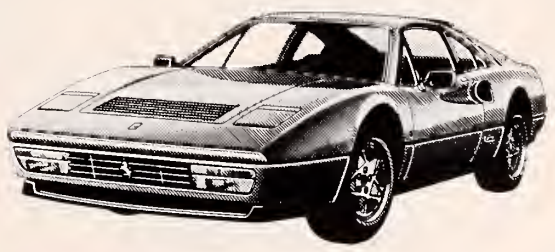
HARRY C. FRYE of Magnolia has been recertified by the American Academy of Family Physicians.

MICHAEL FOOSE and BRENDA HINES announce the opening of The Yazoo Clinic, a family practice, at 110 East Broadway in Yazoo City.

WILLIAM J. GIBSON of Jackson announces the association of ALEXANDER J. HAICK, JR. for the practice of general surgery and surgical oncology.

HILTON L. GILLESPIE, JR. has associated with the Hattiesburg Clinic for the practice of obstetrics and gynecology.

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KEITH GOLDEN has opened his office for the practice of family medicine at Pelatchie Medical Clinic.

JEFFREY HENRY GLOVER, JR. has associated with Jackson Surgical Group for the practice of general surgery.

J. MARK HARRIS announces the opening of the Florence Family Clinic at 116 East Main Street in Florence.

JOHN B. HICKS has associated with Meridian Medical Associates, 1525 22nd Avenue, for the practice of cardiology.

ROBERT W. HIGGINS has associated with Manning, Barrett and Shelton Clinic, 1080 River Oaks Office Plaza in Jackson, for the practice of orthopedic surgery.

JAMES HUGHES of UMC taught a continuing education workshop at Vanderbilt University in Nashville.

BOBBY KING of Iuka recently was honored by the community upon his retirement from the practice of medicine.

RALPH C. KAHLER has associated with The Hattiesburg Clinic for the practice of internal medicine.

HERBERT LANGFORD of UMC was guest speaker for the annual meeting of the American Society of Hypertension in New York City and also served as a review consultant for the National Heart, Lung and Blood Institute in Bethesda, Maryland.

HAL THOMPSON LIDDELL has associated with the Urology Center in Hattiesburg for the practice of urology.

SHERRY A. MARTIN has associated with The Hattiesburg Clinic for the practice of internal medicine.

CHESTER MASTERSON of Vicksburg was installed as president of the Vicksburg Rotary Club.

JUDY L. MCDONALD of Natchez announces the association of JAMES R. BENTLEY with the Natchez Clinic for Women for the practice of obstetrics and gynecology.

LYNN B. MCMAHAN of Hattiesburg was among 15 American physicians who were in the Soviet Union for the opening of the Moscow Research Institute of Eye Microsurgery.

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JOHN W. MCFADDEN of Tupelo presented a paper at the Annual Meeting of the American Academy of Thermology at Johns Hopkins Medical Center in Baltimore and also made a presentation at Repides General Hospital in Alexandria, Louisiana.

GERHARD H. MUNDINGER, JR. has associated with Cardiovascular Clinic in Jackson for the practice of cardiac, vascular and thoracic surgery.

K. D. NAYAK of Laurel announces the association of C. K. VYAS for the practice of cardiology.

WILLIAM KEVIN NICHOLS has associated with Laird Hospital, 215 Peachtree Street in Union, for the practice of family medicine.

WILLIAM T. OAKES, JR. announces the opening of his office for the practice of neurology at 609 Brunson Drive in Tupelo.

SAMUEL C. PACE has reassociated with Internal Medicine Associates of Tupelo for the practice of gastroenterology.

N. DOUGLAS PACKER and CHESTER H. LAKE, JR. have associated with Jackson Anesthesia Associates, 301 Medical Plaza Building, Jackson.

JOHN V. PETRO has joined the staff of Green/Herring/Pendergrass Eye Clinic in Hattiesburg for the practice of ophthalmology.

JOE PULLIAM announces the opening of his office for the general practice of medicine and the formation of a partnership with J. C. CHAUVIN of Aberdeen.

DAVID RICHARDSON has associated with STONEY WILLIAMSON and Hattiesburg Eye Clinic for the practice of ophthalmology.

EDWARD E. RIGDON has associated with Laurel Surgery Clinic for the practice of general, thoracic and vascular surgery.

KENNETH ROBBINS has associated with The Children's Clinic of Jackson for the practice of pediatrics.

WILLIAM T. ROBINSON announces the opening of his office for the practice of general, thoracic and vascular surgery at 404-B Summer Street in Lucedale.

BENJAMIN A. ROOT has associated with Mississippi Neuropsychiatric Clinic in Jackson for the practice of psychiatry.

RANDOLPH J. ROSS of Hattiesburg has been elected to membership in the American Urological Association.

M. CATHERINE SESSUMS has associated with A. DEAN CROMARTIE, JOEL R. FLYNT, and HILDA J. MCGEE of Hattiesburg and Columbia for the practice of obstetrics and gynecology.

JOHN SHELL of Vicksburg has been elected president of the Board of Medical Licensure. Other officers are W. W. WALLEY of Waynesboro, vice-president, and WALTER ROSE of Indianola, secretary.

SUTHIN SONGCHAROEN of Jackson recently spoke at a meeting of the Central Mississippi Chapter of the Lupus Foundation of America.

J. KEITH SPEED announces the opening of his office for the general practice of medicine at 251-A Hospital Drive in Tylertown.

DAVID R. STECKLER and JAMES I. CLARK of Natchez announce the association of EDWARD J. SHUMSKI, JR. in the practice of anatomical and clinical pathology and hematology.

JAMES M. TALKINGTON has associated with T. W. TALKINGTON and S. J. WILDER of Jackson for the practice of sports medicine and orthopedic surgery.

JAMES M. TUCCI has associated with The Hattiesburg Clinic for the practice of neurology.

JACKEY D. TURNER and BETTY HALES TURNER have associated with the Family Medicine Clinic of Kosciusko for the practice of family medicine and pediatrics.

GERALD WESSLER of Gulfport has been promoted to professor of clinical urology at Tulane University School of Medicine.

NEW ADDRESS

MSMA headquarters has moved to 236 East Capitol Street (third floor, Great Southern National Bank). Mailing address continues to be P.O. Box 5229, Jackson, MS 39216.

MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 21-25, 1987, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

State and Local

Mississippi State Medical Association, 119th Annual Session, June 3-7, 1987, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, July 29-August 1, 1987, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, February, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, January, May, and November. H. S. Barrett, Secy., P.O. Box 1810, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington, Yazoo.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, Secy., Mail: Ms. Jenkins, P.O. Box 4053, Meridian 39305. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, Meetings scheduled quarterly. Fred G. Emrich, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, January. Charles S. Watras, 612 Summit St., Winona 38967. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, September, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. William Billington, Secy., 731 Medical Center Dr., West Point, MS 39773. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 1st Wednesday, February, April, June, August, October, December. John J. McCloskey, Secy., 3003 Short Cut Rd., Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. George R. Bush, Secy., 307 S. 13th Ave., Laurel 39440. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly
Mississippi State Medical Association
735 Riverside Drive
Jackson, MS 39216

North Mississippi Medical Center
830 Gloster Avenue
Tupelo, MS 38801

Forrest General Hospital
Box 1897
Hattiesburg, MS 39401

Mississippi Baptist Hospital
1225 N. State Street
Jackson, MS 39201

Gulf Coast Community Hospital
4642 W. Beach Boulevard
Biloxi, MS 39531

Jefferson Davis Memorial Hospital
Box 1488
Natchez, MS 39120

King's Daughter Hospital
Box 948
Brookhaven, MS 39601

Riverside Hospital
Lakeland Drive
Jackson, MS 39208

Biloxi Regional Medical Center
1559 Lafayette St.
Biloxi, MS 39533

Jeff Anderson Regional Medical Center
2124 14th St.
Meridian, MS 39301

Northwest Mississippi Regional Medical Center
Box 1218
Clarksdale, MS 38614

Mississippi Chapter
American College of Surgeons
Box 5229
Jackson, MS 39216

North Panola County Hospital
Drawer 160
Sardis, MS 38666

Singing River Hospital
P.O. Box 112
Pascagoula, MS 39567

Magnolia Hospital
Alcorn Drive
Corinth, MS 38834

Greenwood Leflore Hospital
1508 Leflore Avenue
Greenwood, MS 38930

Gulfport Memorial Hospital
4500 13th Street
Gulfport, MS 39501

Oxford-Lafayette County Hospital
P.O. Box 946
Oxford, MS 38655

Medico-Legal Brief

Opinions of the AMA Council On Ethical and Judicial Affairs

The AMA Council on Ethical and Judicial Affairs presented the following opinions to the AMA House of Delegates at its 1986 Annual Meeting for the information of the delegates.

Referral of Patients — Disclosure of Limitations. When a physician agrees to provide treatment, he thereby enters into a contractual relationship and assumes an ethical obligation to treat the patient to the best of his ability. PPO and HMO contracts generally restrict the participating physician's scope of referral to medical specialists, diagnostic laboratories, and hospitals that have contractual arrangements with the PPO or HMO. Some plans also restrict the circumstances under which referrals may be made to contracting medical specialists. If the PPO or HMO does not permit referral to a noncontracting medical specialist or to a diagnostic or treatment facility when the physician believes that the patient's condition requires such services, the physician should so inform the patient so that the patient may decide whether to accept the outside referral at his own expense or confine himself to services available within the PPO or HMO. In determining whether treatment or diagnosis requires referral to outside specialty services, the physician should be guided by standards of good medical practice.

Economic Incentives and Levels of Care. The primary obligation of the hospital medical staff is to safeguard the quality of care provided within the institution. The medical staff has the responsibility to perform essential functions on behalf of the hospital in accordance with licensing laws and accreditation requirements. Treatment or hospitalization that is willfully excessive or inadequate constitutes unethical practice. The organized medical staff has an obligation to avoid wasteful practices and unnecessary treatment that may cause the hospital needless expense. In a situation where the economic interests of the hospital are in conflict with patient welfare, patient welfare takes priority.

Medical Testimony. As a citizen and as a professional with special training and experience, the physician has an ethical obligation to assist in the administration of justice. If a patient who has a legal claim requests his physician's assistance, the physician should furnish medical evidence, with the patient's consent, in order to secure the patient's legal rights.

The medical witness must not become an advocate or a partisan in the legal proceeding. The medical witness should be adequately prepared and should testify honestly and truthfully. The attorney for the party who calls the physician as a witness should be informed of all favorable and unfavorable information developed by the physician's evaluation of the case. It is unethical for a physician to accept compensation that is contingent upon the outcome of litigation.



ANNOUNCEMENT

PRO MONITORING PROJECT

The American Medical Association is once again urging physicians to relay their experiences, both positive and negative, with Peer Review Organizations, to its headquarters office in Chicago. The PRO Monitoring Project, initiated in March 1985, is part of an ongoing Association activity to keep apprised of developments in the implementation of the federal government's PRO program. Through the project the AMA, to date, has received over 200 written communications on PROs representing the concerns of more than 5,000 individual physicians nationwide.

While the AMA is interested in all relevant experiences, areas of particular interest would include:

- changes in length of stay, admission and discharge policies
- preadmission certification procedures
- notifications to patients on payment denials
- utilization and quality review results
- payment denials based on quality
- administrative relations between hospitals and physicians and the PROs
- any demonstrable impact that PRO review may have on the cost or quality of care
- sanction activities
- appeals processes
- the results of any PRO efforts to review patients other than Medicare beneficiaries.

Physicians or hospital medical staffs who would like to share this information with the AMA are encouraged to describe their experience(s) in a brief letter and direct it to:

AMA PRO Monitoring Project
Department of Health Care Review
American Medical Association
P.O. Box 10947
Chicago, IL 60610

All sources of information provided will be kept confidential. The data will be carefully analyzed and the results used by the AMA as the Association develops new ways to assist physicians and medical staffs in dealing with the PRO program.

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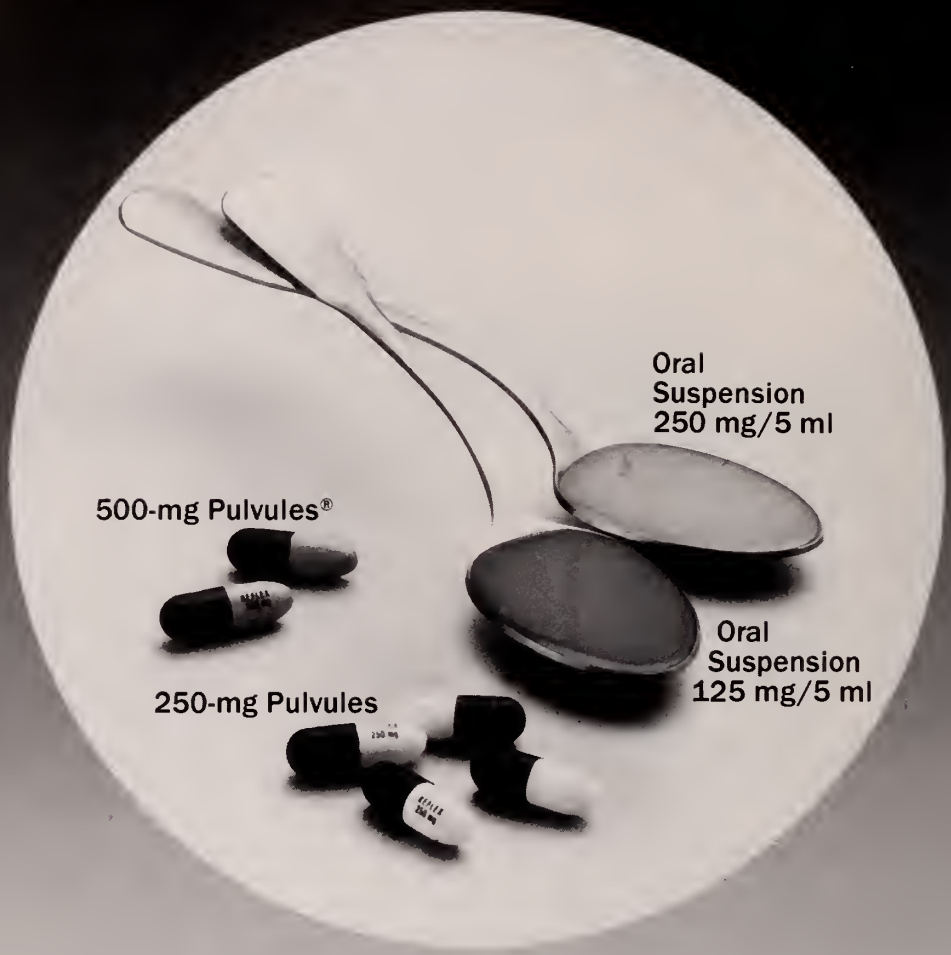
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Nov. 20
EPILEPSY FOR PHYSICIANS 1986
Jackson Country Club

Nov. 21-22
PEDIATRIC ANNUAL MEETING
University Medical Center and
Sheraton Regency Hotel, Jackson

Nov. 7
COMMUNICATIVE DISORDERS SYMPOSIUM
University Medical Center

For information, contact the University of Mississippi Medical Center, Division of Continuing Health Professional Education, 2500 North State Street, Jackson, Mississippi 39216-4505; or call (601)984-1300.

PLACEMENT SERVICE

Physicians Wanted

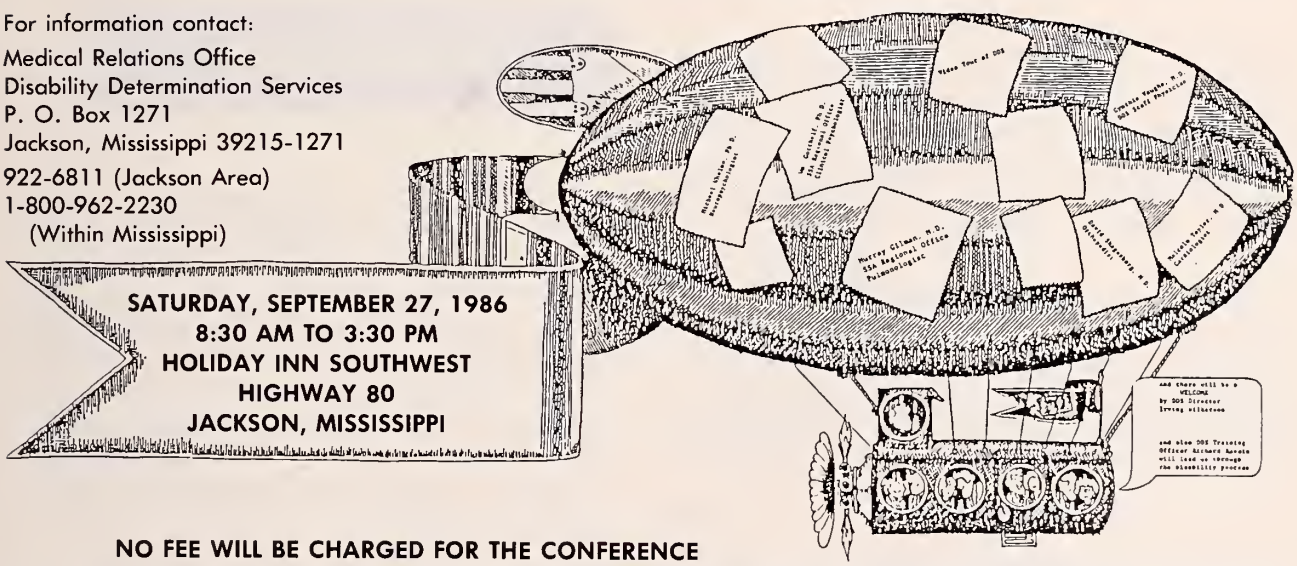
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EMERGENCY PHYSICIANS WANTED. Part-time and full-time positions. Columbus, MS. Call (601) 328-8385.

(Continued)

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For information contact:
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Disability Determination Services
P. O. Box 1271
Jackson, Mississippi 39215-1271
922-6811 (Jackson Area)
1-800-962-2230
(Within Mississippi)



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EMERGENCY ROOM physician needed to staff recently expanded emergency room coverage. Salary negotiable. Small town. 44-bed hospital approved for federal programs, located in central Mississippi. Contact Paul W. Strode, Box 428, Forest, MS 39074.

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FAMILY MEDICINE positions available. Board certified or board eligible family physicians needed by largest multi-specialty group practice in state. Located 75 miles north of Mississippi Gulf Coast. Contact T. G. Thornton, Administrator, Hattiesburg Clinic, 415 South 287th Ave., Hattiesburg, MS 39401; (601) 268-5601.

FAMILY PRACTICE. Northern Mississippi. Extremely profitable practice grossing $235,000 per year. Interest in building and land priced attractively. Financing available for total package. Contact Mike Page, RH Medical Group, Inc., 12651 Briar Forest, Suite 180, Houston, TX 77077. (713) 496-7777.

PEDIATRIC PRACTICE. Mississippi Gulf Coast. Beautiful coastal location; excellent staff will remain. Practice grosses $330,000 per year. Financing available. Contact Mike Page, RH Medical Group, Inc., 12651 Briar Forest, Suite 180, Houston, TX 77077. (713) 496-7777.

For information about MSMA's Placement Service or classified advertising, contact the Managing Editor, P.O. Box 5229, Jackson, MS 39216; 1-800-682-6415 or 354-5433.

PHYSICIANS NEEDED

Physicians (especially specialists such as ophthalmologists, pediatricians, orthopedists, neurologists, etc.) interested in performing consultative evaluations (according to Social Security guidelines) should contact the Medical Relations Office. WATS 1-800-962-2230; Jackson, 922-6811; extensions 2275, 2276, 2249 or 2190.

The Mississippi Disability Determination Services now has a program available for medical society meetings and hospital staff meetings. The purpose of this program is to explain the Social Security Disability program, the medical documentation requirements, and how the disability determination process works. Any group interested in this presentation should also contact the Medical Relations Office.

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Index to Advertisers

Ayerst Laboratories **14A, 14B, 14C, 14D,** 240B, 240C, 240D

Campbell Laboratories 243
Canton Exchange Bank 252
Curtis 1000 Information Systems **7**

Disability Determination Services 257, 258

Ferrari South **251**
Forrest General Hospital **4**

Harreld Chevrolet 248
F. W. Hebert Hospital **14**

Eli Lilly and Company 256B

Medical Assurance Co. of Miss. **8**
Miss. Baptist Medical Center **2**

Miss. Foundation for Medical Care **12**
MSMA Benefit Plan and Trust 236

Premier Printing 252

Roche Laboratories ..... **third, fourth covers**

St. Dominic/Jackson Memorial Hospital 250
Smith Kline and French 240A

U. S. Air Force **6**
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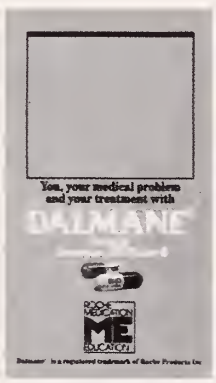
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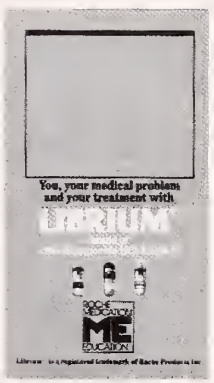
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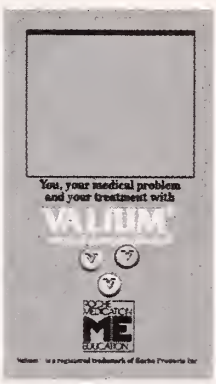
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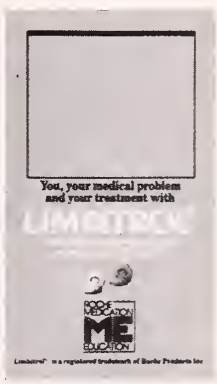
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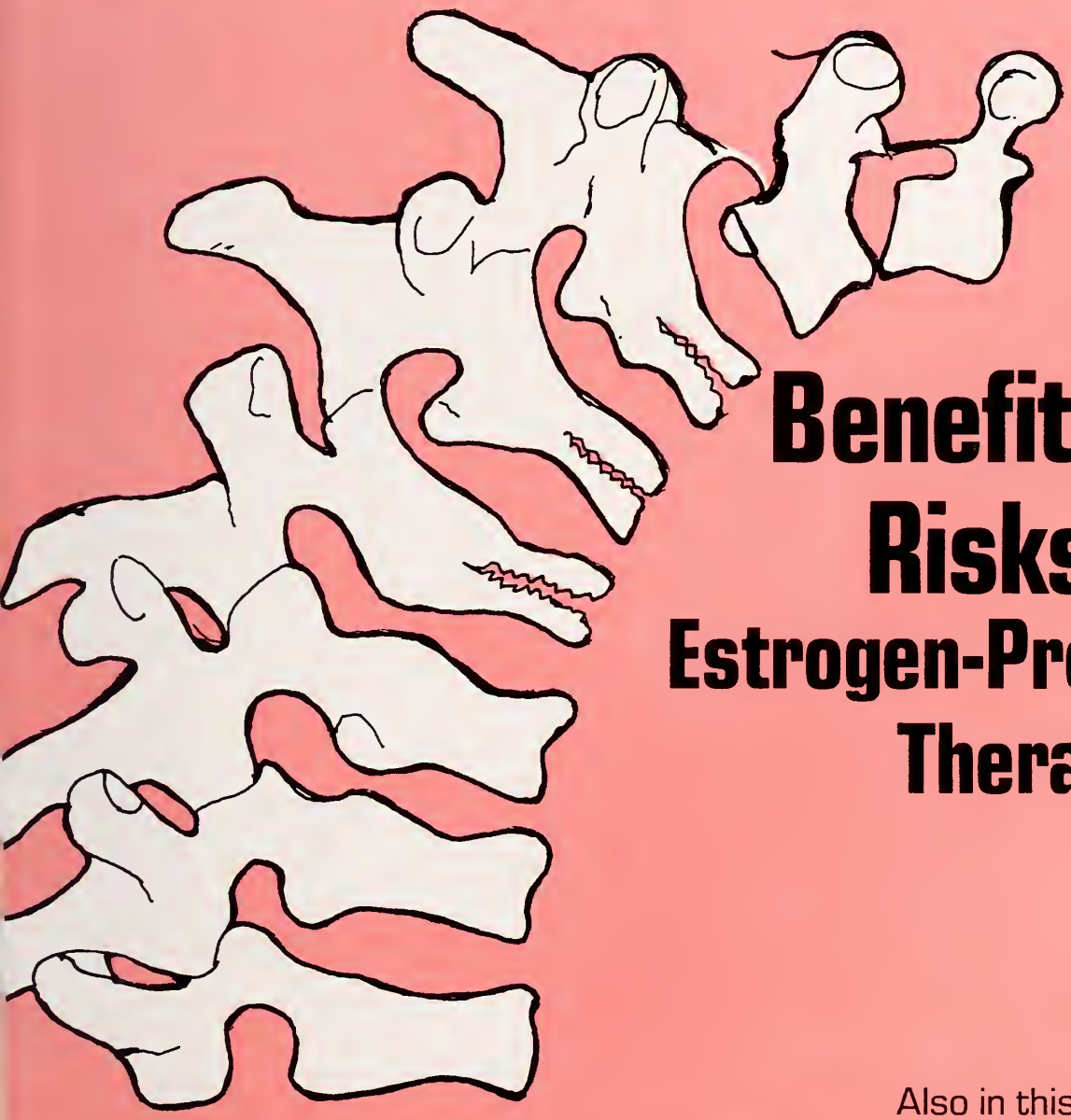
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October 1986

JOURNAL of the MISSISSIPPI State Medical Association

Osteoporosis:



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The Journal of the Mississippi State Medical Association is owned and published monthly by the Mississippi State Medical Association, founded 1856, at P.O. Box 5229, Jackson, Mississippi 39216. Subscription rate, $25.00 per annum; $35.00 per annum for foreign subscriptions; $2.25 per copy, as available. Advertising rates furnished on request. Printed by The Ovid Bell Press, Inc., Fulton, Missouri. Second-class postage paid at Jackson, Mississippi, and at additional mailing offices. POSTMASTER: Send address changes to Mississippi State Medical Association, P.O. Box 5229, Jackson, Mississippi 39216.

CONTENTS

ORIGINAL PAPERS

Perioperative Myocardial Infarction **259** Lee A. Lambert, M.D.

Pott's Paraplegia: Case Report **263** Rodney E. Frothingham, M.D., Alexandre Solomon, M.D., Hugh Gamble, M.D., Darrell Blaylock, M.D. and Walter Rose, M.D.

SPECIAL ARTICLE

James Grant Thompson Memorial Lecture — Osteoporosis: Benefits and Risks of Estrogen-Progestogen Replacement Therapy **267** R. Don Gambrell, M.D.

EDITORIAL

Experience Reveals Need To Review Home Health Services **275** Myron W. Lockey, M.D.

THIS MONTH

274 The President Speaking
275 Letters
276 Comment
276 Medico-Legal Brief
277 Medical Organization
281 New Members
282 Deaths
287 Personals

Cover artwork by Bill Tyler of Jackson.

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(ISSN 0026-6396)

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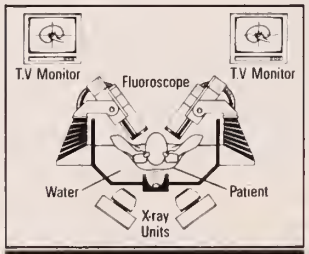


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NEWSLETTER

October 1986

Dear Doctor:

A major expansion of activities of the Joint Commission on Accreditation of Hospitals (JCAH) will take place in 1987, according to Dr. Dennis O'Leary, president. The JCAH, which accredits 5,000 of the nation's 6,500 hospitals and 2,500 other health care facilities, will include evaluation of clinical outcomes as part of its ongoing accreditation process.

> Immediate goals are: (1) to gather clinical information for understanding and predicting outcomes and (2) to change the survey process to continuing, rather than every three years. Long-range goals include surveying all hospitals on their clinical activities as often as quarterly.

Statistics from the Mississippi State Department of Health indicate that the suicide rate in the state has been slowly increasing since the 1950s. In that decade there were 6.0 suicides per 100,000 population, and by the 1980s the rate had increased to 9.7. The increase is particularly significant for younger Mississippians. In 1960 the rate for persons age 15-24 was 2.1 per 100,000 population; by 1985 it was five times higher, 10.8 per 100,000. (Data are based on reported succcessful suicides, and many factors affect reporting.)

Applications to U. S. medical schools declined for the 1985-86 academic year and first-time enrollments fell for the fourth year in a row, according to the 86th Annual Report on Medical Education in the U.S., published in the September 25 issue of JAMA. The nation's medical schools received about 3,000 fewer applications for the 1985-86 year than the year before. Of the 32,893 applicants, 17,228 students were accepted by at least one school for fall 1985 enrollment. The report estimates that 16,191 students will graduate this year, 197 fewer than in 1985, with 59% accepting residency positions in primary care specialties. Also reported were figures on student debt. Average indebtedness for 1985 graduates topped $30,000, nearly double the average for 1980.

Sincerely,

Patsy Silver

Patsy Silver
Managing Editor



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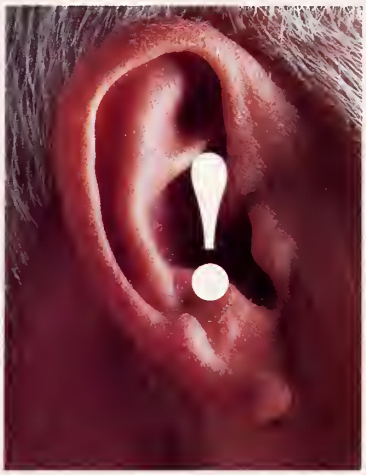
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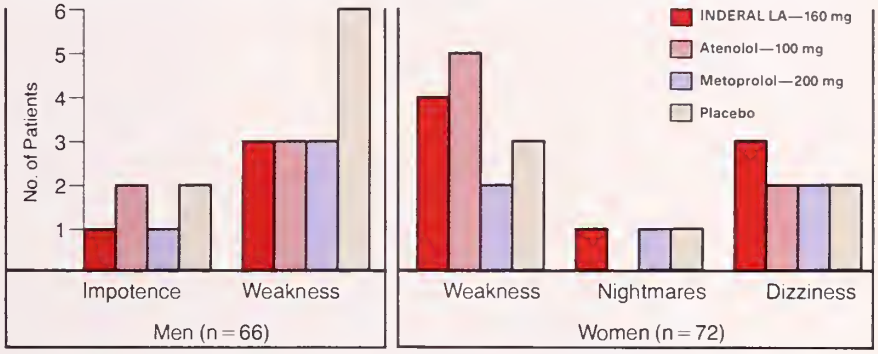
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Propranolol hydrochloride (INDERAL® LA): Propranolol is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs

WARNINGS

Propranolol hydrochloride (INDERAL® LA): CARDIAC FAILURE Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated, and are receiving digitalis and diuretics Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or propranolol should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction following *abrupt* discontinuance of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm Propranolol does not distort thyroid function tests

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker In one case this resulted after an initial dose of 5 mg propranolol

MAJOR SURGERY The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution, since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

DIABETES AND HYPOGLYCEMIA Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes In these patients, it may be more difficult to adjust the dosage of insulin. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease In patients with renal disease, thiazides may precipitate azotemia In patients with impaired renal function, cumulative effects of the drug may develop

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma

Thiazides may add to or potentiate the action of other antihypertensive drugs Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported

PRECAUTIONS

Propranolol hydrochloride (INDERAL® LA): GENERAL Propranolol should be used with caution in patients with impaired hepatic or renal function Propranolol is not indicated for the treatment of hypertensive emergencies

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure Patients should be told that propranolol may interfere with the glaucoma screening test Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase lactate dehydrogenase

DRUG INTERACTIONS Patients receiving catecholamine-depleting drugs, such as reserpine, should be closely observed if propranolol is administered The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension marked bradycardia vertigo, syncopal attacks, or orthostatic hypotension

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential In 18-month studies, in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity There were no drug-related tumorigenic effects at any of the dosage levels Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug

PREGNANCY Pregnancy Category C Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose There are no adequate and well-controlled studies in pregnant women Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

NURSING MOTHERS Propranolol is excreted in human milk Caution should be exercised when propranolol is administered to a nursing mother

PEDIATRIC USE Safety and effectiveness in children have not been established

Hydrochlorothiazide: GENERAL Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely Hyponatremia, hypochloremic alkalosis, and hypokalemia Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids Medication such as digitalis may also influence serum electrolytes. Warning signs irrespective of cause are Dryness of mouth, thirst weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect of digitalis (eg, increased ventricular irritability) Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content.

Any chloride deficit is generally mild and usually does not require specific treatment, except under extraordinary circumstances (as in liver or renal disease) Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening In actual salt depletion, appropriate replacement is the therapy of choice

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy

Insulin requirements in diabetic patients may be increased, decreased, or unchanged Diabetes mellitus which has been latent may become manifest during thiazide administration

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy

Thiazides may decrease serum PBI levels without signs of thyroid disturbance

Calcium excretion is decreased by thiazides Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy The common complications of hyperparathyroidism such as renal lithiasis bone resorption, and peptic ulceration, have not been seen Thiazides should be discontinued before carrying out tests for parathyroid function.

DRUG INTERACTIONS Thiazide drugs may increase the responsiveness to tubocurarine

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use

PREGNANCY Pregnancy Category C. Thiazides cross the placental barrier and appear in cord blood The use of thiazides in pregnancy requires that the anticipated benefit be weighed against possible hazards to the fetus These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult

NURSING MOTHERS Thiazides appear in human milk If use of the drug is deemed essential, the patient should stop nursing

PEDIATRIC USE Safety and effectiveness in children have not been established

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL® LA): Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy

Cardiovascular Bradycardia, congestive heart failure intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency usually of the Raynaud type

Central Nervous System Lightheadedness, mental depression manifested by insomnia lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss; emotional lability slightly clouded sensorium, and decreased performance on neuropsychometrics

Gastrointestinal Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea constipation; mesenteric arterial thrombosis, ischemic colitis

Allergic Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress

Respiratory Bronchospasm

Hematologic Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura

Auto-Immune In extremely rare instances, systemic lupus erythematosus has been reported

Miscellaneous Alopecia; LE-like reactions, psoriasiform rashes; dry eyes, male impotence; and Peyronie's disease have been reported rarely Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol

Hydrochlorothiazide:

Gastrointestinal Anorexia; gastric irritation, nausea, vomiting, cramping, diarrhea constipation; jaundice (intrahepatic cholestatic jaundice), pancreatitis; sialadenitis

Central Nervous System Dizziness, vertigo; paresthesias, headache; xanthopsia

Hematologic Leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia

Cardiovascular Orthostatic hypotension (may be aggravated by alcohol, barbiturates or narcotics).

Hypersensitivity Purpura, photosensitivity rash, urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis) fever respiratory distress, including pneumonitis, anaphylactic reactions

Other Hyperglycemia glycosuria, hyperuricemia, muscle spasm; weakness, restlessness, transient blurred vision

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn

* The appearance of these capsules is a registered trademark of Ayerst Laboratories

REFERENCE:

1. Ravid M, Lang R, Jutrin I The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily *Arch Intern Med* 1985 145 1321–1323

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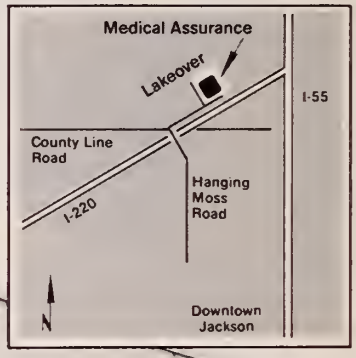
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DATELINE

Legal/Medical Seminar Is Scheduled in Jackson

Jackson, MS - MSMA members are urged to attend a comprehensive legal/medical seminar for physicians on November 7-8 in Jackson. The seminar, cosponsored by Miss. Defense Lawyers Association and UMC, will present prominent speakers on current developments on professional liability issues in the state. For more information, contact the Miss. Defense Lawyers Association, P.O. Box 12314, Jackson, MS 39236-2314; phone 956-7787.

HMO/IPA Operations Pending Contract

Jackson, MS - After completing its market research, PHP of Ohio presented its management plan for operation of the MSMA-sponsored HMO/IPA. The boards of the HMO/IPA reviewed and discussed the plan, which was presented on September 11, and voted to enter into negotiations with PHP leading toward a management contract. Current plans call for early completion of the contract negotiations and beginning operations.

Funds Requested for Chlamydia Screening

Jackson, MS - The state health department is requesting $150,000 to provide a test for chlamydia in its prenatal screenings. A pilot test program last year indicated the disease has reached epidemic proportions among the department's pregnant patients. Officials say the test will save money because of costly complications of the disease. Annually, 16,000 of the state's 45,000 pregnant women receive their care from the state health department.

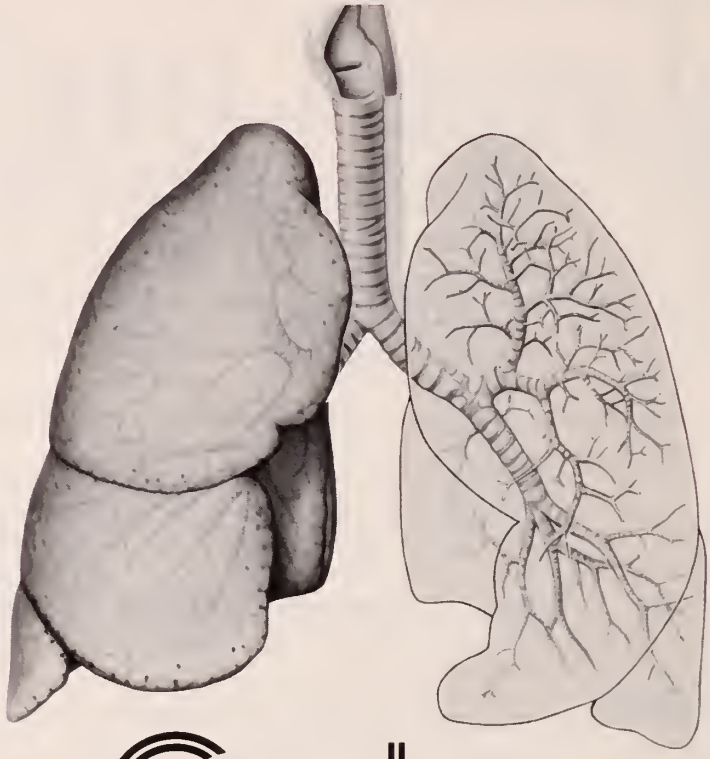
MEC Addresses Problem of Liability Insurance

Jackson, MS - The Mississippi Economic Council (MEC) has joined a growing list of public and private organizations in the state which have established special committees and study groups to address the issue of liability insurance. According to the MEC, a recent survey indicates that the problem of liability insurance is the most serious problem facing its members today.

New DPT Vaccine Causes Fewer Reactions

Chicago, IL - Two research groups writing in the American Journal of Diseases of Children (September) report encouraging results of studies comparing a conventional DPT vaccine with a new vaccine using an acellular pertussis component. In the studies, from Vanderbilt and UCLA, antibody response to both vaccines was comparable, but the acellular variety caused fewer reactions. The report cautions more trials are needed.

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Haemophilus influenzae, H influenzae, Streptococcus pneumoniae, Streptococcus pyogenes
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Note: Ceclor® is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Ceclor® (cefaclor)

Summary. Consult the package literature for prescribing information.

Indications: Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae, Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci).

Contraindications: Known allergy to cephalosporins.

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- In renal impairment, safe dosage of Ceclor may be lower than that usually recommended. Ceclor should be administered with caution in such patients.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, erythema multiforme, serum-sickness-like reactions): 1.5%; usually subside within a few days after cessation of therapy. These reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children)
- Abnormal urinalysis; elevations in BUN or serum creatinine
- Positive direct Coombs' test
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly)

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CONFIRMED

CONFIRMED BY CLINICAL EVIDENCE

ZANTAC® 150 h.s.

ranitidine HCl/Glaxo 150 mg tablets

EFFECTIVE MAINTENANCE THERAPY

for healed duodenal ulcer patients

CONFIRMED

In two randomized, double-blind, and well-controlled clinical trials, ZANTAC 150 mg h.s. significantly superior to cimetidine 400 mg h.s. for maintenance therapy in healed duodenal ulcers.

Percent of patients with observed duodenal ulcer recurrence

		0-4 months	0-8 months	0-12 months	No. patients
USA[1]	ranitidine 150 mg h.s.	9%	14%*	16%†	60
	cimetidine 400 mg h.s.	23%	34%	43%	66
UK, Ireland, Australia[2]	ranitidine 150 mg h.s.	8%‡	14%‡	23%‡	243
	cimetidine 400 mg h.s.	21%	34%	37%	241

*p=0.02
†p=0.01
‡p≤0.004
%=life-table estimates
All patients were permitted prn antacids for relief of pain.

These two trials used the currently recommended dosing regimen of cimetidine (400 mg h.s.) and ranitidine (150 mg h.s.). A comparison of other dosing regimens has not been studied.

The studied dosing regimens are not equivalent with respect to the degree and duration of acid suppression or suppression of nocturnal acid.

The superiority of ranitidine over cimetidine in these trials indicates that the dosing regimen currently recommended for cimetidine is less likely to be as successful in maintenance therapy.

Convenient once-a-night dose with a

low incidence of side effects[3]

Headache, sometimes severe, seems to be related to ranitidine administration. Other side effects have been reported; for a complete listing, see the **ADVERSE REACTIONS** section in the Brief Summary.

No significant interference with the hepatic cytochrome

P-450 enzyme system at recommended doses

ZANTAC 150 mg has no significant drug interactions with theophylline, phenytoin, or warfarin. The bioavailability of certain medications whose absorption is dependent on a low gastric pH may be altered when ZANTAC or other medications that decrease gastric acidity are administered.

Zantac® 150

ranitidine HCl/Glaxo 150 mg tablets

One tablet at bedtime
for maintenance

See next page for references and
Brief Summary of Product Information.

Glaxo / ROCHE®

CONFIRMED

Zantac® 150

ranitidine HCl/Glaxo 150 mg tablets

One tablet at bedtime for maintenance therapy in healed duodenal ulcer patients

References:

1. Silvis SE, Griffin J, Hardin R, et al: Final report on the United States multicenter trial comparing ranitidine to cimetidine as maintenance therapy following healing of duodenal ulcer. *J Clin Gastroenterol* 1985;7(6):482-487.
2. Gough KR, Korman MG, Bardhan KD, et al: Ranitidine and cimetidine in prevention of duodenal ulcer relapse: A double-blind, randomised, multicentre, comparative trial. *Lancet* 1984;ii:659-662.
3. Data available on request, Glaxo Inc

ZANTAC® 150 Tablets
(ranitidine hydrochloride)
ZANTAC® 300 Tablets
(ranitidine hydrochloride)

BRIEF SUMMARY OF PRODUCT INFORMATION

See complete product information before prescribing. The following is a brief summary.

INDICATIONS AND USAGE: ZANTAC® is indicated in:
1. Short-term treatment of **active duodenal ulcer**. Most patients heal within four weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer**. Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD)**. Symptomatic relief commonly occurs within one or two weeks after starting therapy. Therapy for longer than six weeks has not been studied.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: ZANTAC® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS: General: 1. Symptomatic response to ZANTAC® therapy does not preclude the presence of gastric malignancy. 2. Since ZANTAC is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function. Caution should be observed in patients with hepatic dysfunction since ZANTAC is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during ZANTAC therapy, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions: Although ZANTAC has been reported to bind weakly to cytochrome P-450 in vitro, recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions which suggest that ZANTAC may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no indication of tumorigenic or carcinogenic effects in lifespan studies in mice and rats at doses up to 2,000 mg/kg/day.

Ranitidine was not mutagenic in standard bacterial tests (*Salmonella, E coli*) for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next nine weeks.

Pregnancy: ***Teratogenic Effects: Pregnancy Category B:*** Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ZANTAC. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: ZANTAC is secreted in human milk. Caution should be exercised when ZANTAC is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Use in Elderly Patients: Ulcer healing rates in elderly patients (65 to 82 years of age) were no different from those in younger age groups. The incidence rates for adverse events and laboratory abnormalities were also not different from those seen in other age groups.

ADVERSE REACTIONS: The following have been reported as events in clinical trials or in the routine management of patients treated with oral ZANTAC®. The relationship to ZANTAC therapy has been unclear in many cases. Headache, sometimes severe, seems to be related to ZANTAC administration.

Central Nervous System: Rarely, malaise, dizziness, somnolence, insomnia, and vertigo. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients.

Cardiovascular: Rare reports of tachycardia, bradycardia, and premature ventricular beats.

Gastrointestinal: Constipation, diarrhea, nausea/vomiting, and abdominal discomfort/pain.

Hepatic: In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid IV for seven days, and in 4 of 24 subjects receiving 50 mg qid IV for five days. With oral administration there have been occasional reports of reversible hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice.

Musculoskeletal: Rare reports of arthralgias.

Hematologic: Rare reports of reversible leukopenia, granulocytopenia, thrombocytopenia, and pancytopenia.

Endocrine: Controlled studies in animals and man have shown no stimulation of any pituitary hormone by ZANTAC and no antiandrogenic activity, and cimetidine-induced gynecomastia and impotence in hypersecretory patients have resolved when ZANTAC has been substituted. However, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving ZANTAC, but the incidence did not differ from that in the general population.

Integumental: Rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia.

Other: Rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia) and small increases in serum creatinine.

DOSAGE AND ADMINISTRATION: Active Duodenal Ulcer: The current recommended adult oral dosage is 150 mg twice daily. An alternate dosage of 300 mg once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

Maintenance Therapy: The current recommended adult oral dosage is 150 mg at bedtime.

Pathological Hypersecretory Conditions (such as Zollinger-Ellison Syndrome): The current recommended adult oral dosage is 150 mg twice a day. In some patients it may be necessary to administer ZANTAC® 150-mg doses more frequently. Doses should be adjusted to individual patient needs, and should continue as long as clinically indicated. Doses up to 6 g/day have been employed in patients with severe disease.

Benign Gastric Ulcer: The current recommended adult oral dosage is 150 mg twice a day.

GERD: The current recommended adult oral dosage is 150 mg twice a day.

See full prescribing information for dosage adjustment for patients with impaired renal function.

HOW SUPPLIED: ZANTAC® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) and unit dose packs of 100 tablets (NDC 0173-0393-47).

ZANTAC® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 tablets (NDC 0173-0344-42) and unit dose packs of 100 tablets (NDC 0173-0344-47).

Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.

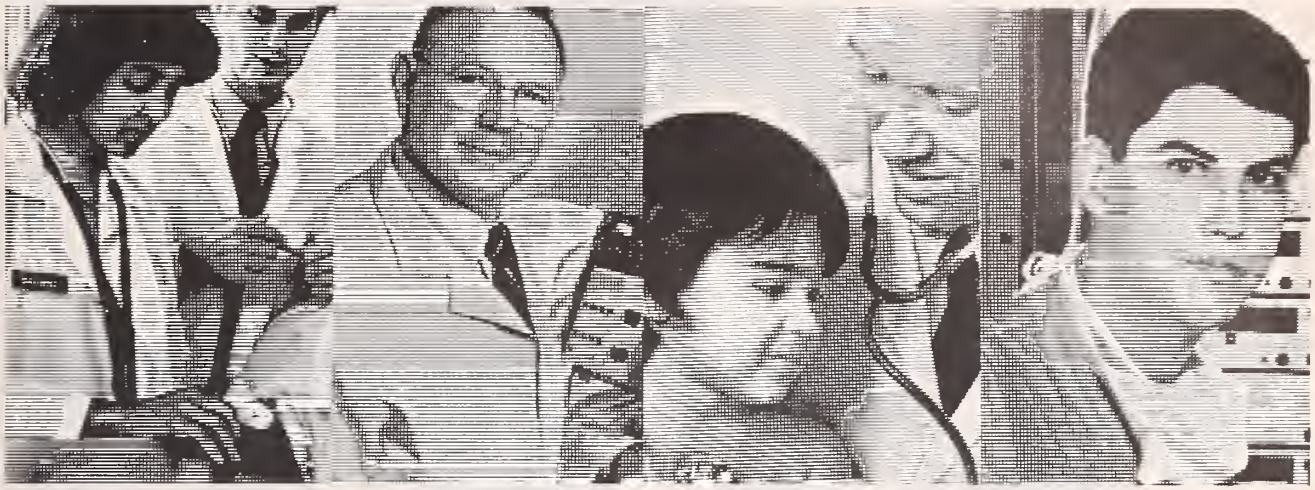
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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
October 1986, XXVII, Number 10

ORIGINAL PAPERS

Perioperative Myocardial Infarction

LEE A. LAMBERT, M.D.
Ocean Springs, Mississippi

Perioperative myocardial infarction (PMI) is a continuing complication, frequently lethal, in the surgical population. The incidence is likely to climb with the growing number of geriatric patients presenting or returning for surgery. Another attributing factor is the rise in noncardiac surgery performed on cardiac patients. The author notes that any patient data serving as evidence of a predisposition toward PMI can alert physicians to optimally prepare and manage the patient through the stress of anesthesia, surgery and recovery. He discusses preoperative factors associated with PMI.

THE COMPLICATION of myocardial infarction in a surgical patient who received anesthesia is quite sobering. It also may seem paradoxical, when the anesthesiologist attempted with reasonable success to maintain the patient's physiology as near to normal as humanly possible. Despite this, perioperative myocardial infarction (PMI) occurs. Since most surgery is of a noncardiac nature, this discussion will not include PMI involving cardiac surgery.

Some obvious questions arise concerning this subject. What is the incidence and mortality of PMI? Who are those at increased risk? What measures can be done to optimize a patient's cardiac status preceding surgery? How is the patient managed intraoperatively who is predisposed to PMI?

It appears from the literature that the occurrence of PMI in the overall adult surgical population is less than 1%.[1, 2] Patients having a recent myocardial infarction (MI) are at even greater risk of reinfarcting. Those having an MI six months or longer preceding the date of surgery have a 5% incidence of PMI. This is increased to 26% if the previous MI occurred 3-6 months before surgery. Finally, a patient with a previous MI three months or less preceding the date of surgery and anesthesia has up to a 37% incidence of PMI![3, 4] This information is well documented and known among our internist and surgeon friends. Other more obvious patients prone to PMI include those with new-onset angina or unstable angina or those in poor general medical condition. So what is new?

Usually, in a typical clinical setting, an anesthesiologist does not see these types of patients the day before surgery. Nevertheless, daily we manage patients with histories of dysrhythmias, stable angina, previous myocardial infarction, congestive heart failure, hypertension, peripheral vascular disease, anemia, diabetes mellitus, as well as many who are elderly.

The obvious has always been easy to recognize. However, the not-so-obvious is what needs exploring if we are to know the preoperative factors suggestive of an underlying condition that may have a causal relationship with PMI.

Dr. Lambert is engaged in the private practice of anesthesiology.

One group of clinicians addressed this issue in a prospective study of 1001 patients over 40 years of age.[5] The surgery was major and noncardiac in nature. They found a statistically significant correlation between certain preoperative factors and postoperative life-threatening or fatal complications such as pulmonary edema, ventricular tachycardia and myocardial infarction. Each of these complications was associated with a 25 percent or greater incidence of cardiac death. These preoperative factors were: (1) S_3 gallop or jugular-vein distention on preoperative examination; (2) myocardial infarction in preceding six months; (3) rhythm abnormality other than sinus, or premature atrial contractions on preoperative electrocardiogram; (4) > 5 premature ventricular contractions per minute documented at any time before operation; (5) intraperitoneal, intrathoracic or aortic operation; (6) age > 70 years; (7) important valvular aortic stenosis; (8) emergency operation; and (9) poor general medical condition.*

The highest percentage of cardiac complications, both life-threatening but nonfatal and cardiac death, were associated with the first four risk factors above. Other preoperative factors considered but found not to be significant were hyperlipidemia, smoking, diabetes, hypertension, peripheral atherosclerotic vascular disease, stable angina, old myocardial infarction by history or electrocardiography, ST-segment or T-wave changes, mitral valve disease, bundle-branch blocks and congestive heart failure in the absence of a third heart sound or jugular-vein distention. These investigators then computated a weight for each risk factor in the form of points (see Table 1). The point system was divided into four classes (see Table 2), with Class I consisting of the fewest points and Class IV the greatest range of points. Naturally Class I had the least number of cardiac complications and moving toward Class IV cardiac complications increased. There were two conclusions from their data: (1) the recommendation that only truly life-saving procedures be performed on patients with risk-index scores of 26 points or more (Class IV) and (2) those patients with scores of 13 to 25 points (Class III) probably have sufficient cardiac risk to warrant routine preoperative medical consultation from a cardiac standpoint.

Intraoperative factors that correlate with PMI are episodes of hypotension (decreases in blood pressure of 20-30% below baseline) lasting 5-15 minutes, hypertension and tachycardia in patients with and without a previous MI.[2, 4, 7] The location of surgery as well as duration has been correlated with PMI in patients with and without a previous MI. Here noncardiac thoracic and upper intra-abdominal surgery lasting greater than three hours may be contributing factors.[4, 6]

One must keep in mind that comparing equally the data of different studies on PMI and its predisposing factors is ludicrous. Over the last 3½ decades in which many of the studies have been published, new and more efficacious medical protocols and anesthetic management have emerged. Some of the studies preceded the advent of beta-adrenergic blockers and calcium channel blockers, which no doubt move toward better preparing a patient with coronary artery disease for surgery.

Another variable entering the picture and altering

TABLE 1

PREOPERATIVE RISK FACTORS AND THEIR COMPUTATED WEIGHT IN THE FORM OF POINTS

	Points
1. History	
(a) Age > 70 years	5
(b) MI in previous 6 months	10
2. Physical Examination	
(a) S_3 gallop or JVD	11
(b) Important VAS	3
3. Electrocardiogram	
(a) Rhythm other than sinus or PAC's	7
(b) 5 PVC's minute documented at anytime before operation	7
4. General Status: $PO_2 < 60$ or $PCO_2 > 50$ mmHg; $K < 3.0$ or $HCO_3 < 20$ meg/liter; BUN > 50 or Cr > 3.0 mg/dl; Abnormal SGOT, signs of chronic liver disease or patient bedridden from noncardiac causes	3
5. Operation:	
(a) Intraperitoneal, intrathoracic or aortic	3
(b) Emergency operation	4
Total Points Possible	53

Abbreviations:

MI	=	myocardial infarction
JVD	=	jugular-vein distention
VAS	=	valvular aortic stenosis
PAC's	=	premature atrial contractions
K	=	potassium
HCO_3	=	bicarbonate
SGOT	=	serum glutamic oxaloacetic transaminase
ECG	=	electrocardiogram
PVC's	=	premature ventricular contractions
PO_2	=	partial pressure of oxygen
PCO_2	=	partial pressure of carbon dioxide
BUN	=	blood urea nitrogen
Cr	=	creatinine

*Partial pressure of oxygen < 60 mm Hg, partial pressure of carbon dioxide > 50 mm Hg, potassium < 3.0 or bicarbonate < 20 meg/liter, blood urea nitrogen > 50 or creatinine > 3.0 mg/dl, elevated transaminase, signs of chronic liver disease or patient bed ridden from noncardiac causes.

results from comparative studies of PMI has been the introduction of new anesthetic agents and techniques used to maintain a favorable myocardial oxygen supply/demand relationship. Considering our progress in these two areas, the incidence and mortality of PMI should lessen from which it has in one article.[4]

Once the identification of the patient predisposed to PMI is made, measures can be instituted to better prepare him or her for the stress of anesthesia, surgery and recovery. This may include treating pulmonary problems to improve oxygenation, transfusion to increase oxygen-carrying capacity of the blood, and correcting dysrhythmias and congestive heart failure with antidysrhythmics and inotropic agents (digoxin) respectively. These improve myocardial oxygen supply. Determinants of myocardial oxygen demand are heart rate, contractility, preload (ventricular filling) and afterload (systemic vascular resistance). Tachycardia is treated with beta-adrenergic blockers, contractility can be decreased with beta-adrenergic blockers and calcium-channel blockers, preload can be lessened through nitrate administration and diuresis and elevated afterload countered with a direct-acting vasodilating antihypertensive. These measures will optimize from a cardiovascular standpoint a patient who begins surgery at an unusually higher risk of having a cardiac insult.

PMI usually appears following surgery. It may be subtle and present clinically as unexplained hypotension or tachycardia in the immediate postoperative period. It may be symptomatic, although the likelihood of a silent infarct seems greater in the postoperative patient since incisional pain and analgesics may mask angina. In this circumstance serial 12-lead ECGs and specific cardiac enzyme studies can detect an evolving PMI. The knowledge of a PMI presenting several days following surgery discounts the impression that anesthesia and surgery per se is the period in which the patient is in the most jeopardy of having an MI. Therefore, the recovery period demands our meticulous attention to controlling cardiovascular parameters, avoiding hypoxemia and correcting inadequate perfusion through lowered cardiac output. The mortality of PMI varies among studies. PMI has been associated with a 42-83% mortality.[1, 2, 3, 6] Mortality has been attributed to a malignant dysrhythmia or low cardiac output due to myocardial failure.

TABLE 2

Cardiac Risk Index AS DETERMINED BY THE NUMBER OF PREOPERATIVE RISK FACTORS (TABLE 1) PRESENT

Class	*Point Range*
I	0-5
II	6-12
III	13-25*
IV	≥ 26+

* These patients have sufficient cardiac risk to warrant routine preoperative medical consultation from a cardiac standpoint.
+ These patients should probably have only truly life-saving surgical procedures performed.

In summary, the recognition of certain preoperative factors found in the medical history, physical examination and laboratory data usually singles out the patient susceptible to a PMI. Identification of this type of patient allows us to optimize his/her cardiac status even if it means foregoing elective noncardiac surgery until corrective coronary artery bypass surgery is performed. Anesthetic management includes maintaining a favorable balance between myocardial oxygen supply and demand not only during surgery but throughout the recovery period. Only then shall we see less PMI. ★★★

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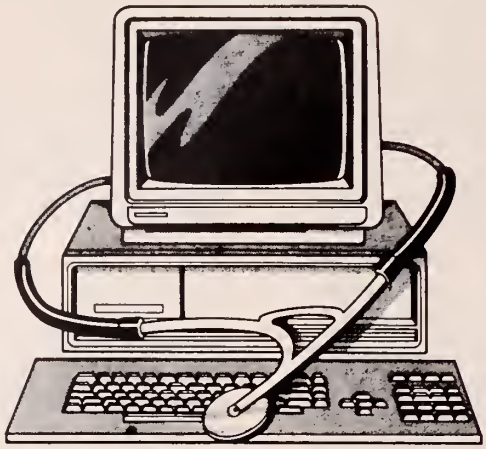
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Pott's Paraplegia: Case Report

RODNEY E. FROTHINGHAM, M.D., ALEXANDRE SOLOMON, M.D., HUGH GAMBLE, M.D., DARRELL BLAYLOCK, M.D., and WALTER ROSE, M.D.
Greenville, Mississippi

WHILE THE NUMBER of reported cases of tuberculosis has decreased, the incidence of tuberculosis of the spine has been little affected. Pott's paraplegia or Pott's disease was described by Percival Pott in 1779.[1] Spinal tuberculosis has actually been found in Egyptian mummies, attesting to the ancient nature of the disease.[2]

This case report represents the first case of Pott's Paraplegia reported to the Mississippi State Health Department in several years. While this disease has almost become a rarity on the North American continent and in other developed countries, physicians should continue to be aware that it has by no means vanished as a clinical entity.

Case Report

This 40-year-old woman was diagnosed as having pulmonary tuberculosis in 1983. She was treated with Ethambutol and Streptomycin. Her pulmonary tuberculosis cleared, and treatment was discontinued in 1985 (see Figure 1).

On January 3, 1986, she presented with symptoms of bilateral lower extremity weakness, impairment of proprioception, paresthesias, vague chest pain and abdominal swelling. A tentative diagnosis of a cold tuberculosis abscess of the thoracic spine was made based on clinical symptoms, examination, and chest x-ray (see Figure 2). Her symptoms rapidly progressed and she become unable to stand and developed marked sensory impairment below the mid-trunk level. She became incontinent of urine, requiring an in-dwelling catheter.

A myelogram showed a complete block at the level of the sixth thoracic vertebra. CT scan revealed bony destruction of the fifth and sixth vertebral bodies (see Figure 3), and a large right paravertebral mass at this level (see Figure 4).



Figure 1

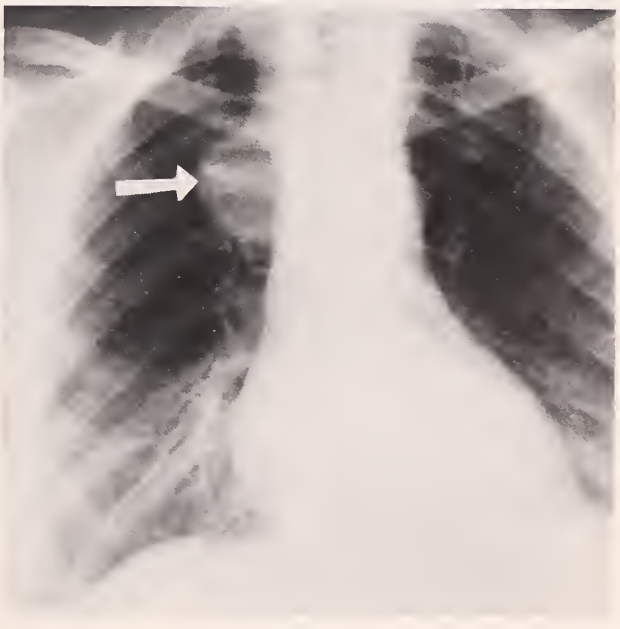


Figure 2

From the Department of Neurosurgery (Drs. Frothingham and Solomon), Department of Surgery (Dr. Gamble), and Department of Medicine (Dr. Blaylock), Delta Medical Center, Greenville, MS. Dr. Rose is engaged in the private practice of medicine in Indianola, MS.



Figure 3



Figure 4



Figure 5

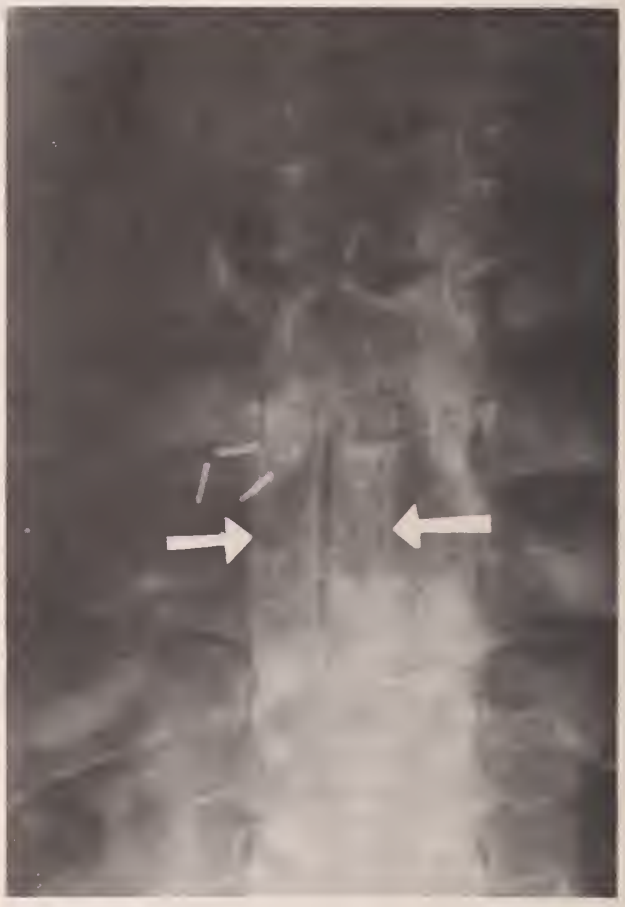


Figure 6

Operative Technique

Because of the x-ray findings, a right thoracotomy was performed with resection of the fifth rib. The rib was saved for use as a strut graft following removal of the diseased vertebra. The abscess was opened and approximately 80 cm^3 of purulent drainage was obtained. Bacteriological studies showed acid fast bacilli.

The vertebral bodies of T-5 and T-6 were totally destroyed and were removed to expose the spinal canal. The dura, although quite thickened, was intact. An epidural abscess was drained at the time the primary paravertebral abscess was opened. A mortis was prepared in the inferior surface of the 4th vertebral body and the superior surface of the 7th vertebral body, to receive the strut grafts prepared from the rib which had been removed at the time of the thoracotomy. These grafts were firmly driven into place and attempts to dislodge them confirmed their stability. Post-operative CT scan (see Figure 5) and thoracic spine X-ray (see Figure 6) confirm excellent bone (rib) strut placement.

Postoperative Course

Over the course of the next two to three weeks, the patient showed rapid and gratifying recovery. She was able to ambulate with the assistance of a four-point walker and in a Boston bucket brace. Her bladder function returned to normal with no post-voiding residual.

Pre- and post-operative anti-tuberculous therapy consisted of Rifampin (Rifadin) 600 mgs P.O. daily; Ethambutol (Myambutol) 1gm P.O. daily; Pyrizandamide (PZA) 500 mgs P.O. four times a day; and Streptomycin 1 gm IM three times a week.

Summary

This case presents a woman with tuberculosis of the thoracic spine resulting in a high paraplegia. She was successfully treated with decompression followed by stabilization and medical treatment. Her response to treatment has been extremely gratifying. This case certainly calls attention to the fact that while tuberculosis has become an uncommon disease, relatively speaking, it certainly has not been eradicated. ★★★

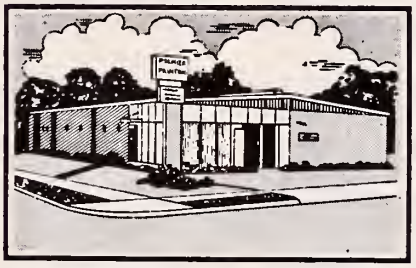
Dr. Frothingham, 526 Fairview Avenue (38701)

Acknowledgement

The authors wish to thank Don Williamson, M.D., and Charlotte Powell, RN, both with the Mississippi State Board of Health Tuberculosis program, who were of great assistance in both the care of this patient and in the preparation of this manuscript.

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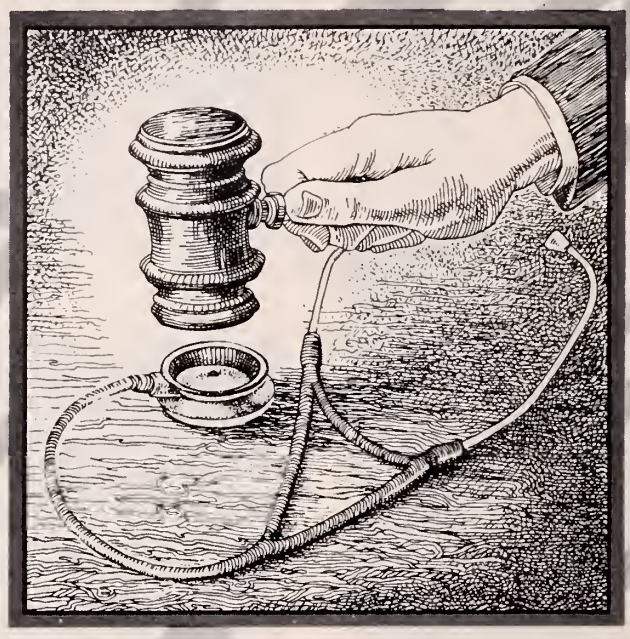


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SPECIAL ARTICLE

James Grant Thompson Memorial Lecture

Osteoporosis: Benefits and Risks of Estrogen-Progestogen Replacement Therapy

R. DON GAMBRELL, JR., M.D.
Augusta, Georgia

Postmenopausal osteoporosis affects 25-50% of older women and increases the risk for vertebral, hip, and other fractures. Estrogen therapy for menopausal complaints has received adverse publicity because several reports have indicated that unopposed estrogens increase the risk of endometrial cancer. The author notes that added progestogen not only negates this risk but reduces the incidence of endometrial adenocarcinoma in estrogen-progestogen users to less than that observed in untreated women. Estrogen replacement therapy does not increase the risk of breast cancer; however, the incidence of this malignancy was also less in the estrogen-progestogen users when compared either to the untreated women or from that expected from the national cancer surveys. In evaluating postmenopausal women for hormone replacement, the benefits of estrogen-progestogen therapy must be weighed against possible risks.

Osteoporosis is a skeletal disorder primarily affecting trabecular bone in which a reduction in the quantity of bone predisposes to fracture. Although both sexes lose bone mass with aging, it is rare for men to develop symptomatic osteoporosis before age 70. This is a major public health problem affecting 20,000,000 older Americans, of which 90% are postmenopausal women.[1] It is estimated that there are 1,700,000 fractures each year from osteoporosis at an annual public health cost in excess of $3.8 billion. Approximately 25% of white women over the age of 60 have spinal compression fractures and this number increases to 50% by the age of 75. With increasing longevity, a woman now reaching the age of 50 has a life expectancy of 80.4 years, at which age the already serious morbidity and mortality associated with osteoporosis becomes even greater. Of all hip fractures, 80% are associated with osteoporosis, and 34% of all patients with hip fracture die within 6 months.[2]

Several studies have demonstrated that estrogen therapy prevents osteoporosis, decreases vertebral and other fractures, and prevents further loss of height. However, estrogen replacement therapy continues to be controversial although it is making a comeback during the 1980s. It was fashionable in the 1960s to prescribe estrogens for continued youthfulness, but in the 1970s the complications of hormone therapy became apparent. Physicians were reluctant to treat the climacteric, and patients became wary of hormone therapy. A woman's lifespan has steadily increased, so that today more than one-

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Presented to the 119th Annual Session of the Mississippi State Medical Association, Biloxi, Mississippi, June 7, 1986.

third of her years are postmenopausal. The declining ovarian function — rapid for some, slower for others — provokes a variety of disturbances in some women but may be entirely asymptomatic. In addition to vasomotor symptoms such as hot flushes, genital atrophy may lead to vulvo-vaginitis and irritation. Metabolic changes occur subsequent to estrogen deficiency in addition to osteoporosis, psychosomatic manifestations may occur, and even atherosclerotic heart disease.

The incidence of cancer of the endometrium or breast need not increase as a result of long-term therapy if cyclic progestogens in adequate dosages are added to the estrogen regimen. Not all postmenopausal women require estrogen therapy, since some women produce sufficient endogenous estrogens to remain asymptomatic and prevent the metabolic changes of later life. However, within this group are certain individuals who require progestogen therapy to prevent endometrial hyperplasia and subsequent neoplasia.

Osteoporosis can be prevented in 90% of postmenopausal women with conjugated estrogens 0.625 mg daily or cyclicly from the first through the 25th of the month. If osteoporosis is already present, and 30% of bone is lost before it is recognized on routine x-rays, higher dosages of estrogen are required, such as conjugated estrogens 1.25 to 2.5 mg. In one long-term prospective study of 1,000 women treated with estrogens for 15 years (14,318 patient-years of observation), wrist fractures were reduced by 70% from the expected rate.[3] No hip fractures occurred during 15 years of estrogen therapy in these 1,000 women. In a carefully controlled study from the Mayo Clinic, patients treated with calcium carbonate 1,500 to 2,000 mg daily, had fewer fractures than those treated with placebo.[4] Fracture rate was reduced by 61% in those treated with calcium plus fluoride 50 to 60 mg daily. However, the most effective therapy was the combination of conjugated estrogens, fluoride and calcium, and the addition of vitamin D had no significant effect. The recommendations of the National Institutes of Health Consensus Development Conference on Osteoporosis are that estrogen replacement therapy is the best prevention of osteoporosis; calcium supplementation, which should be begun about age 40 when women have their peak bone mass, which is also approximately ten years prior to menopause; and that weight-bearing exercise is the best activity to prevent osteoporosis. Elemental calcium 1,000 mg daily should be given to women with normal endogenous estrogens or those on estrogen therapy; higher dosages of 1,500 to 2,000 mg daily are required for women who can not take estrogens.

Prevention of postmenopausal osteoporosis may not be unique to estrogens, since therapy with injectable progestogen is also effective in preventing bone loss. The addition of a progestogen to estrogen therapy may be important in preventing osteoporosis but may be essential in treating patients who already have osteoporosis. Where most studies indicate that estrogen therapy inhibits the resorption of calcium from bone, most likely by restoring calcitonin levels that are decreased after menopause, at least three studies have shown that the combination estrogen-progestogen therapy may actually increase bone mass by promoting new bone formation.[5-7] In a 10-year double-blind prospective study, significant differences were observed between patients receiving cyclic estrogen-progestogen therapy and a group given placebo.[5] In this study, if the combination estrogen-progestogen therapy was begun less than three years after last menstruation, bone density actually increased. Although there was some bone demineralization in the estrogen-progestogen users when therapy was started later than three years after menopause, the loss of bone mass was significantly less than in either placebo group. This study emphasizes the importance of beginning estrogen-progestogen therapy early into menopause, but also indicates that these hormones are beneficial to osteoporotic women, irregardless of age.

Christiansen et al[6] in a crossover study comparing the effects of estrogen-progestogen therapy with placebo, demonstrated that bone mineral content increased during the three years of combination hormone therapy but continued to decline in the placebo-treated group (see Figure 1). When some patients in the estrogen-progestogen group were changed to placebo, bone density decreased; bone mass increased in the placebo-treated women after they were changed to active hormone therapy. Another group compared the effects of estrogens only to estrogen-progestogen combination on the metabolic parameters of bone loss: plasma calcium, urinary calcium/creatinine ratio, and hydroxyproline.[7] All values were diminished with estrogen therapy and decreased further when a progestogen was added to the estrogen.

Other Benefits of Estrogen-Progestogen Replacement Therapy

Vasomotor Symptoms

Most postmenopausal women seek medical attention for hot flushes, or hot flashes, as described

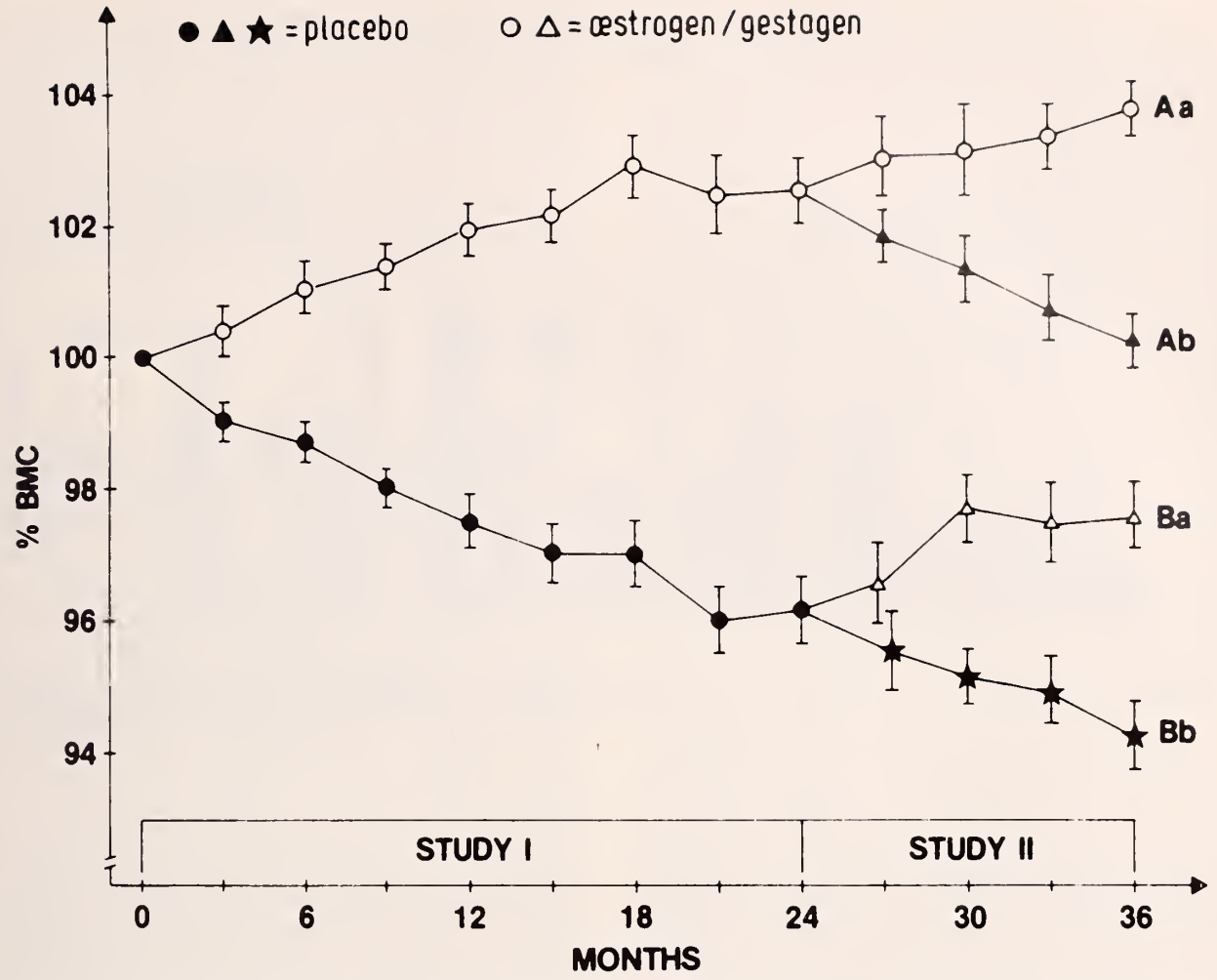


Figure 1. Bone mineral content as a function of time and treatment in 94 (study I) and 77 (study II) postmenopausal women. (Reproduced with permission of the author and publisher.[6])

by some. Vasomotor instability, manifested by hot flushes or night sweats, usually has an insidious onset and increases as serum estrogens decline. Vasomotor symptoms are quite variable in frequency and severity and may persist for several months to a few years. If untreated, the hypothalamus and autonomic nervous system gradually adjust to the lower levels of estrogen, and eventually hot flushes abate. Patients with gonadal dysgenesis display high levels of gonadotropins; yet these individuals experience vasomotor symptoms only after exposure to exogenous estrogens and subsequent withdrawal. The concept of prescribing estrogens to tide patients through the menopause is no longer valid. True, low dosages of estrogen can be taken for short intervals and then weaned so that hot flushes fade. Women do not "go through menopause"; once they become estrogen deficient, they will remain so the rest of their lives. The real goal of estrogen replacement is to prevent the metabolic consequences of later life such as osteoporosis and atherosclerosis.

Urogenital Atrophy

Atrophy of the genital epithelium may result in senile vaginitis with symptoms of irritation, burning, pruritis, leukorrhea, dyspareunia, and occasionally even vaginal bleeding. Vaginal secretions decrease, the vaginal epithelium may become thin and easily traumatized, and the vagina may shorten and become less distensible. To a lesser extent, vulvar epithelium also becomes thin and may be irritated. Since the integrity of the lower urinary tract mucosa is estrogen-dependent, irritative symptoms such as dysuria and burning on urination may occur, and episodes of cystitis may become more frequent. Urethral caruncles and non-gonococcal urethritis occur almost entirely in postmenopausal women.

Psychosomatic Complaints

Many postmenopausal women complain of increased nervousness, depression, anxiety, insomnia, and headaches. Pre-existing psychosomatic problems may be intensified simply because of hot flushes. Libido may be decreased due to atrophic vaginitis; however, an occasional patient experiences increased libido because of freedom from the fear of pregnancy. Sexual dysfunction in the menopausal woman, long regarded by psychologists and sex therapists as entirely psychogenic in origin, has been repeatedly shown to be responsive to hormonal therapy. Relief may be afforded by estrogens for such complaints as vaginal dryness and dyspareunia and by androgens when loss of sex interest is the basis of the problem. Headaches are frequently regarded as psychosomatic and not hormone related. Although recent studies fail to prove that the psychogenic manifestations of climacteric women are hormone-dependent, most indicate that many are at least hormone-responsive.

Coronary Artery Disease

Myocardial infarction rarely occurs in women before menopause unless there is some underlying heart disease. Younger women who undergo bilateral oophorectomy before age 40 demonstrate a higher incidence of myocardial infarction unless estrogen replacement therapy is begun soon after the ovaries are removed. Several recent clinical and epidemiologic studies suggest that estrogens exert a protective effect on atherosclerotic heart disease. Burch et al[3] observed a 63% decrease in deaths from heart disease in 1,000 estrogen-treated women followed for 15 years. Hammond et al[8] found a significantly lower incidence of coronary artery disease ($P < 0.001$) in estrogen-treated women compared to untreated controls. They also observed a much lower incidence of congestive heart failure and atherosclerotic cardiovascular disease in the estrogen users.

Two recent reports in the same issue of the *New England Journal of Medicine* reached conflicting conclusions regarding estrogen use and cardiovascular disease.[9, 10] Particularly disappointing was the report from the Framingham heart study, since so much good information about the relationship between HDL cholesterol and coronary heart disease has come from this group.[9] In fact, this latest report confirmed significantly improved HDL cholesterol, LDL cholesterol, and total cholesterol: HDL cholesterol ratios in the estrogen users when compared to the nonusers. The disappointment is that although estrogen use produced a more favorable lipid pattern, cardiovascular mortality did not differ between estrogen users and nonusers. The Nurses' Health Study confirmed all the earlier reports that postmenopausal estrogen use significantly reduced the risk of coronary disease ($RR = 0.5$; $P = 0.007$), that current use reduced the risk even lower ($RR = 0.3$; $P = 0.001$), and that these benefits held after adjustment for the many variables.[10] After all, estrogen therapy should be protective from heart disease, since it increased HDL cholesterol.

Potential Risks of Hormone Replacement Therapy

Endometrial Cancer

Unopposed estrogens have a role in the development of endometrial hyperplasia, a precancerous lesion in some women, and neoplasia, primarily because of incomplete shedding of the endometrium. Several retrospective studies since 1975 indicate that the risk of endometrial cancer is increased in estrogen users from 1.7 to 8.0-fold. There is now sufficient evidence from both the U.S. and England to indicate that opposing estrogen therapy with cyclic progestogens will prevent most endometrial cancer.[11-14] Progestogens ensure more complete sloughing of the endometrium, leaving fewer cells and glands behind to continue proliferation and overgrowth. Though the protective action of progestogens on the endometrium is primarily physical, there are other actions of both endogenous progesterone and synthetic progestogens that are important. Progestogens decrease estrogen receptors in endometrial cells and induce both estradiol dehydrogenase and isocitrate activity, the enzymes by which endometrial cells metabolize and excrete estrogens. During the reproductive years, the human corpus luteum produces progesterone for 13-14 days during a normal 28-day cycle. Therefore, it is only logical that progestogens should be given to estrogen-treated women for at least 13 days during a 30 or 31-day month.

Progestogen therapy for postmenopausal estrogen users was introduced at Wilford Hall USAF Medical Center in 1971 and a prospective study was begun in 1975. To identify those postmenopausal women at greatest risk for endometrial cancer, both estrogen-treated patients and those who were asymptomatic, the progestogen challenge test was given. The test is administered by prescribing a trial of progestogen, either Provera® 10 mg or Aygestin® 5 mg, for 13 days to each postmenopausal woman with an intact uterus. If withdrawal bleeding results from the progestogen challenge, the progestogen should be continued for 13 days each month for as long as withdrawal bleeding follows.

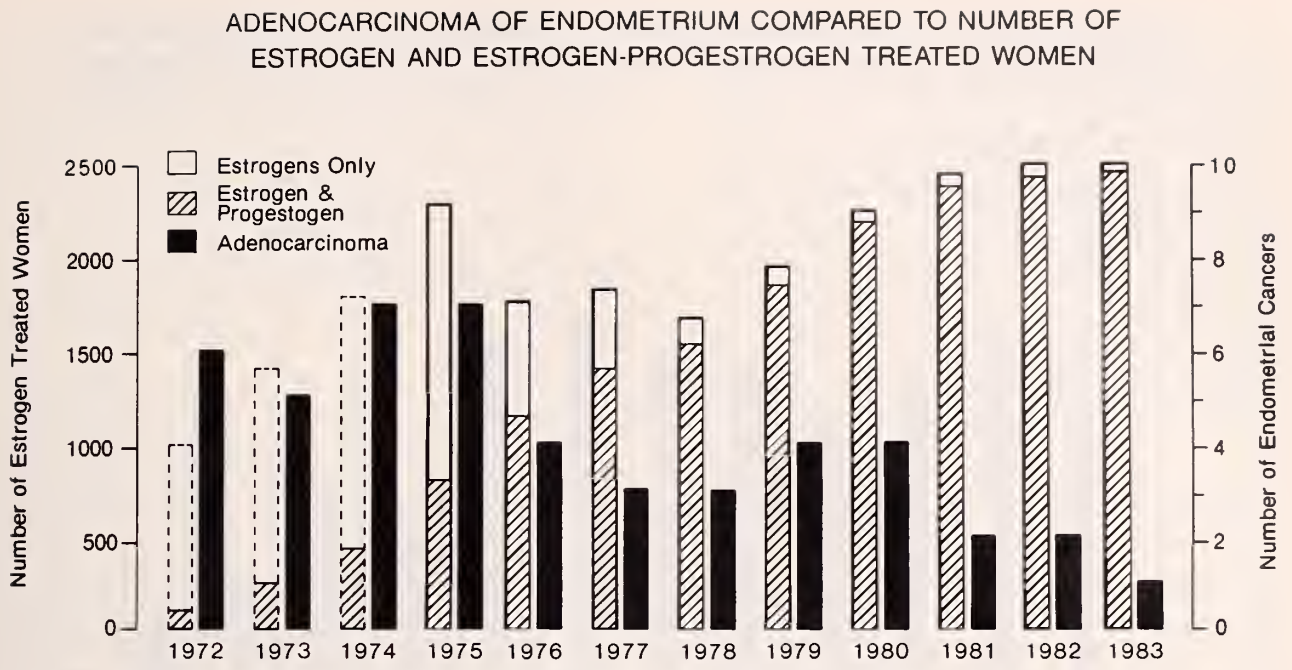


Figure 2. Number of estrogen and estrogen-progestogen users each year compared with the number of endometrial cancers. Solid lines indicate prospective and follow-up study while broken lines indicate retrospective data. (Reproduced with permission of the publisher from Gambrell.[11])

Figure 2 compares the number of estrogen users and estrogen-progestogen users to the number of cases of endometrial cancer at Wilford Hall USAF Medical Center each year for the 12 years from 1971 through 1983. With ever increasing estrogen use from approximately 1,000 postmenopausal women in 1972, to 2,300 during 1975, there was no increase in the cases of endometrial cancers: 6 in 1972, 5 in 1973, and 7 each in 1974 and 1975. However, with ever increasing addition of progestogens, from 10% of the estrogen users in 1972 to 99% by 1983, the number of cases of cancer decreased from 7 in 1975 to 3 or 4 each during the next 5 years, and finally down to a single case by 1983.

From 1975 through 1983, adenocarcinoma of the endometrium was diagnosed in 31 patients at Wilford Hall during 27,243 patient-years of observation, for an overall incidence of 113.8:100,000 women per year. Eight cases were diagnosed in the estrogen-progestogen users during 16,327 patient-years of observation, for an incidence of 49.0:100,000 women. Ten cases were found in the unopposed estrogen users during 2,560 patient-years for an incidence of 390.6:100,000 and 9 cases were detected in the untreated women or non-hormone users during 4,480 patient-years for an incidence of 245.5:100,000. The difference between the estrogen-progestogen users (49.0:100,000) and the unopposed estrogen users (390.6:100,000) was highly statistically significant with $P < 0.0001$. Not only did the estrogen-progestogen users have a significantly lower incidence of this malignancy than the unopposed estrogen users, but they also had a significantly lower incidence of cancer than the untreated women (245.5:100,000) with $P < 0.005$. In other words the estrogen-progestogen users were at less risk for endometrial cancer than those women not using any hormones.

Breast Cancer

Unfortunately, carcinoma of the breast will strike 1 in 11 women in the United States. It is the most frequent malignancy in females, comprising 26% of all cancers.[15] It was the leading cause of death from cancer in women until 1986, responsible for 18% of all female cancer deaths. The American Cancer Society estimates the lung cancer mortality will exceed breast cancer deaths during 1986 for the first time, with 41,400 women dying from carcinoma of the lung while 39,900 women will die from breast cancer.

During the nine years from 1975 through 1983, 69 breast cancers were diagnosed during 48,669

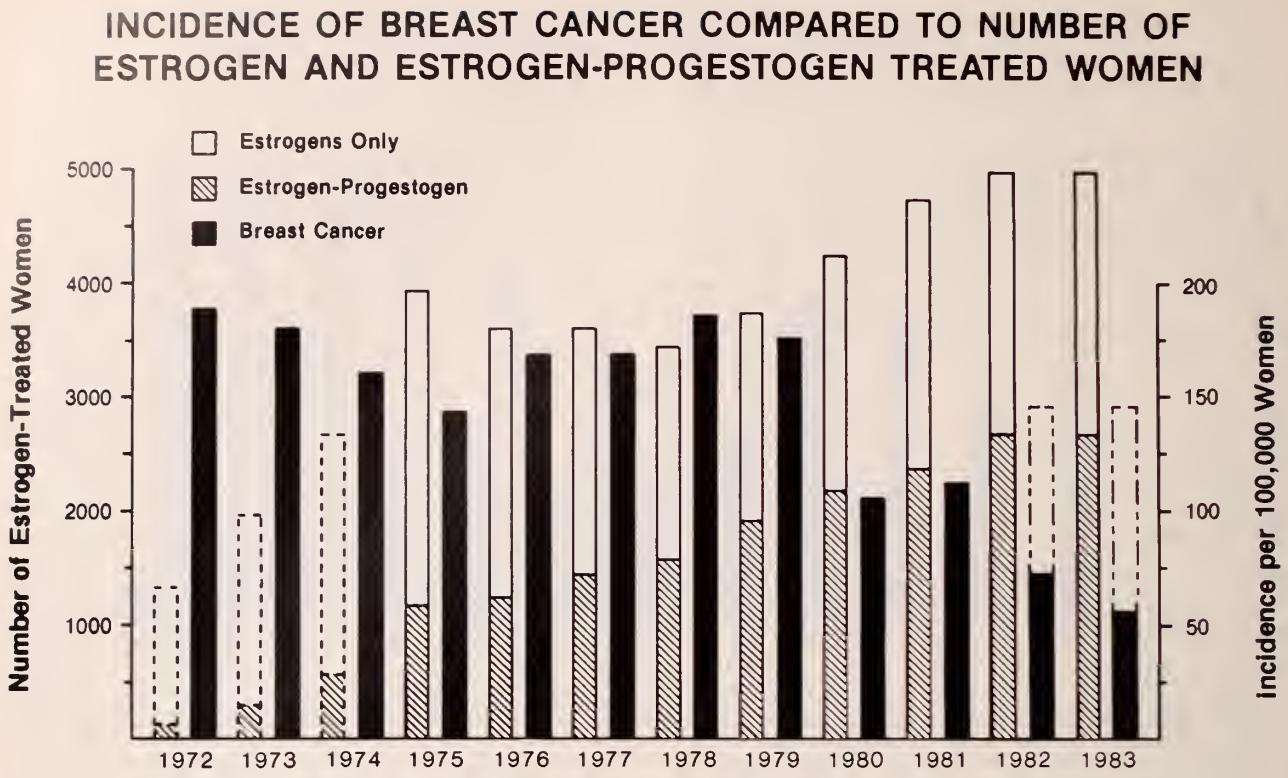


Figure 3. Comparison of the number of estrogen and estrogen-progestogen users with the incidence of breast cancer each year. Solid lines indicate prospective and follow-up study, broken lines illustrate retrospective data, while semi-broken lines (1982-1983) indicate cancer in past users. (Reproduced with permission of the publisher from Gambrell.[11])

patient-years of observation at Wilford Hall, for an overall incidence of 141.8:100,000 women per year. This group was larger than the study population for endometrial carcinoma since hysterectomized women were included, although not those who had a previous mastectomy. The lowest incidence of breast cancer was observed in the estrogen-progestogen users, with 11 patients found to have mammary malignancy, including two past users, during 16,466 patient-years of observation for an annual incidence of 66.8:100,000 women. The expected incidence of breast cancer in this age group, according to the Third National Cancer Survey in 188.3:100,000, and for ages 55 to 59, according to the National Cancer Institute SEER data, is 229.2:100,000. The incidence of breast cancer in our estrogen-progestogen users (66.8:100,000) was significantly lower than our own control group, the untreated women (343.5:100,000), and from that expected from both the Third National Cancer Survey and the National Center Institute SEER data with $P < 0.01$.

The incidence of breast carcinoma in our unopposed estrogen users (142.3:100,000) was significantly lower than in our untreated group (343.5:100,000) with $P < 0.01$, as well as that expected from the NCI SEER data (229.2:100,000) with $P < 0.05$. However, it was not significantly different than that expected according to the Third National Cancer Survey (188.3:100,000). In fact there are no studies anywhere, contrary to popular opinion, that estrogen replacement therapy increases the risk for carcinoma of the breast. Figure 3 compares the number of estrogen and estrogen-progestogen treated women to the incidence of breast cancer for the 12 years from 1972 through 1983, including three years of retrospective data from 1972-1974. With ever increasing estrogen usage, from approximately 1,320 patients in 1972 to 3,940 estrogen-treated women during 1975, there was no increase in the incidence of mammary malignancy. However, with increasing progestogen addition, from approximately 9.1% of the estrogen users in 1972 to 61.1% of the estrogen users by 1983, a

significant decrease in the incidence of breast cancer occurred in the ninth and tenth years, declining from 183.8:100,000 in 1978 to 104.2:100,000 in 1980, 110.4:100,000 in 1981, and finally down to 53.9:100,000 in the continuing users during 1983. If the nine past users are included during 1982 and 1983, the incidence rose slightly to 143.8:100,000. These women had not used any hormones for 3 to 6 years with a mean interval of discontinuance of 4.5 ± 0.87 years.

Conclusions

Reserving hormone replacement therapy only for the accepted symptoms of menopause, ie, severe vasomotor symptoms and atrophic vaginitis, ignores the view that menopause is far more complex in nature. The proven and almost universally accepted benefits of estrogen replacement therapy not only include relief of hot flushes, prevention of atrophic vaginitis and prevention of osteoporosis, but also may help alleviate some of the psychogenic manifestations that are aggravated by the menopause. Furthermore, decreasing the risk of cardiovascular disease, especially in oophorectomized young women, may be an additional benefit by estrogen-induced HDL cholesterol. Thirteen days of cyclic progestogen reduces the risk of endometrial cancer to less than that of women taking no hormones. The risk of breast cancer has not been shown to be increased with estrogen therapy and progestogens provide additional protection from this tumor. Where estrogens prevent demineralization of bone, the addition of a progestogen apparently promotes new bone formation. Therefore, estrogen replacement should no longer be withheld from postmenopausal women since the benefits clearly exceed the risks, especially with added progestogen. ★★★

Augusta, Georgia (30912)

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The President Speaking

Let's Talk Budget

W. JOSEPH H. BURNETT, M.D.
Oxford, Mississippi

I have briefly mentioned on Presidential visits that "it may not be necessary for several years, if ever, to come back to you for a dues increase." Of course, as with most things, there are qualifications, but the trends for MSMA's growth and profit profiles seem to indicate this is a reasonable prediction.

I had the privilege to serve several years on our Council on Budget and Finance. During 1980 our management and growth generated a profitable profile for MSMA's operations. It seemed our income from data processing, etc. might soon exceed dues income; therefore, MSMA Services Inc. was incorporated to protect the tax exempt status of MSMA. Since that time and with the successful organization of MSMA Benefit Plan and Trust, we have experienced exceptional growth. I am happy to report that during this period since 1980 MSMA and MSMA Services Inc. have gone through their first million-dollar budget and this year I predict will budget over three million dollars! !

Now we all have an opportunity to grow with *our* organization. As many of you know, units for investment in our building program will be made available to our members. The estimated annual return for your investment is 12-15% over a five year period. We have tenants and our newly organized HMO should add to this advantage. I don't know of a better investment in Mississippi, not to mention an investment in *our* organization.

Of course, we all appreciate the work of our councils and the dedicated guidance of the Board of Trustees which helped bring MSMA to this point. I would be remiss however not to also give credit for this tremendous growth and success to our entire MSMA staff and their exceptional management. They get theirs the "old-fashioned way. They earn it."

Thanks from all of us! !

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XXVII, NUMBER 10
OCTOBER 1986

Experience Reveals Need To Review Home Health Services

On a recent vacation trip through several states I frequently found myself off the freeways and on the smaller roads, visiting a number of small towns. After visiting several communities, I became aware of the presence of a new type of business in each town. In most instances it was located in the central business district next to the drug, hardware, grocery and department stores. This observation interested me and I began to look at other communities. Almost without exception I found such a business, sometimes more than one, in a given community. I then began to recall other trips through many of these same communities and could not remember any such business being present in the past. I am referring to the sudden appearance of many businesses offering home health services.

These services were developed in response to the national challenge to reduce hospital costs. The business community quickly realized the potential for this service, which now absorbs a large portion of the health care dollar.

Several questions have since come to mind regarding this new service. Primary among these questions is quality assurance. At a time when all aspects of hospital care are undergoing severe scrutiny I have to wonder what measures are protecting the patient and third party payors in their dealings with home health agencies. In reviewing my experiences with some of these agencies, I began to find that in many instances the agencies attempted to prescribe services which I did not desire. If this one fact alone is universal, then a question of appropriate utilization must be raised.

I think that it is appropriate and necessary for us, as physicians, to review our relationship with these agencies and to assure that only those patients who will actually benefit from such services are placed with these agencies and that only the services ordered will be rendered.

MYRON W. LOCKEY, M.D.
Editor

The editors invite your comments, inquiries, and suggestions. Please address letters to the Editors, *Journal of the Mississippi State Medical Association*, P.O. Box 5229, Jackson, MS 39216.

LETTERS

TO DR. DERRICK:

You were exactly right . . . some of our "peers" can be our worst "enemies!"

After 16 years, it isn't "fun" anymore — MFMC, PRO, DRG's, Utilization Review Committees, Quality Assurance Officers, HMO/IPA, Malpractice, etc.

Whatever happened to: "Above all, do no harm." Or "Cure, when possible; relieve pain and suffering always." These are the admonitions that I remember from medical school days and have tried to practice.

However, it seems that all one's "peers" are concerned about are: "justifying one's diagnoses," "lengths of stay," "profit vs. loss," and "putting down" one's colleagues in order to "compete."

I went to medical school, not "marketing" school.

WALTER C. GOUGH, M.D.
Drew, MS

COMMENT

Long Term Frozen Storage Of Autologous Blood

Mississippi Blood Services (MBS) has initiated a program of long term frozen storage of autologous blood. The program was developed in the event that some individuals without imminently anticipated surgery or blood loss may wish to store their own blood for long periods in case of possible need in the future. The expiration date for frozen/deglycerolized red blood cells is three years from the date of collection.

Long term frozen autologous blood storage is expensive and the cost may not be covered by insurance. Candidates for this program will be those whose fear of transfusion is such that the psychological peace of mind will justify the cost. The Blood Center is the ideal provider of this service in the community since it already has the facilities, staff, expertise, licenses, and relationships with hospitals to provide the service at the lowest possible cost to patients. Despite these cost saving factors, however, the expense to those participating in the program will be in excess of $175 per unit stored.

The major disadvantage of this program is that most blood given to young individuals is provided in emergency situations. The time required to thaw, process and deliver frozen/deglycerolized red blood cells to the hospital makes emergency transfusion almost impossible. In addition, once thawed and ready for transfusion, the blood must be infused within 24 hours. Should the expected use be delayed or cancelled, the units which have been prepared would be lost.

One complicating feature of a long term personal blood repository is the potential diversion of attention from community need. New tests are being initiated by MBS to further decrease the incidence of post transfusion hepatitis. These tests will decrease the donor pool by up to 5%. If significant numbers of healthy donors decide to freeze their blood for autologous use only, the blood supply could be further compromised.

The program has been established because it is felt that a small segment of the community perceives a need for this service. If the public perceives a need, the regional blood center's responsibility is to respond appropriately.

Further information may be obtained by contacting Carl Schrader at 984-3753 in Jackson.

FRANCIS MORRISON, M.D.
ROLAND SAMSON, M.D.
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Jackson, MS

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Medico-Legal Brief

AMA And The Supreme Court

An important part of the role of AMA's Office of the General Counsel (OGC) is to protect physician and patient interests in the courts, particularly the United States Supreme Court. This past year AMA was involved as a direct party, or as a friend of the court, in six Supreme Court cases. Five of these cases have been decided in the last few weeks. Let me briefly review three of the cases for you because I believe the precedent they establish will be with us for a long time and will affect the practice of medicine in ways beyond the particular context in which the cases arose.

In *Otis R. Bowen, Secretary of Health and Human Services, Petitioner v. American Hospital Association, et al.* (the *"Baby Doe"* case), the Court at our urging strongly reaffirmed the importance of

(Continued on page 289)

MEDICAL ORGANIZATION

Board of Trustees Conducts Summer Meeting

MSMA's Board of Trustees and Officers held their regular summer meeting on August 16-17 and handled a busy agenda to include referrals from the recent annual session of the House of Delegates and new items of business.

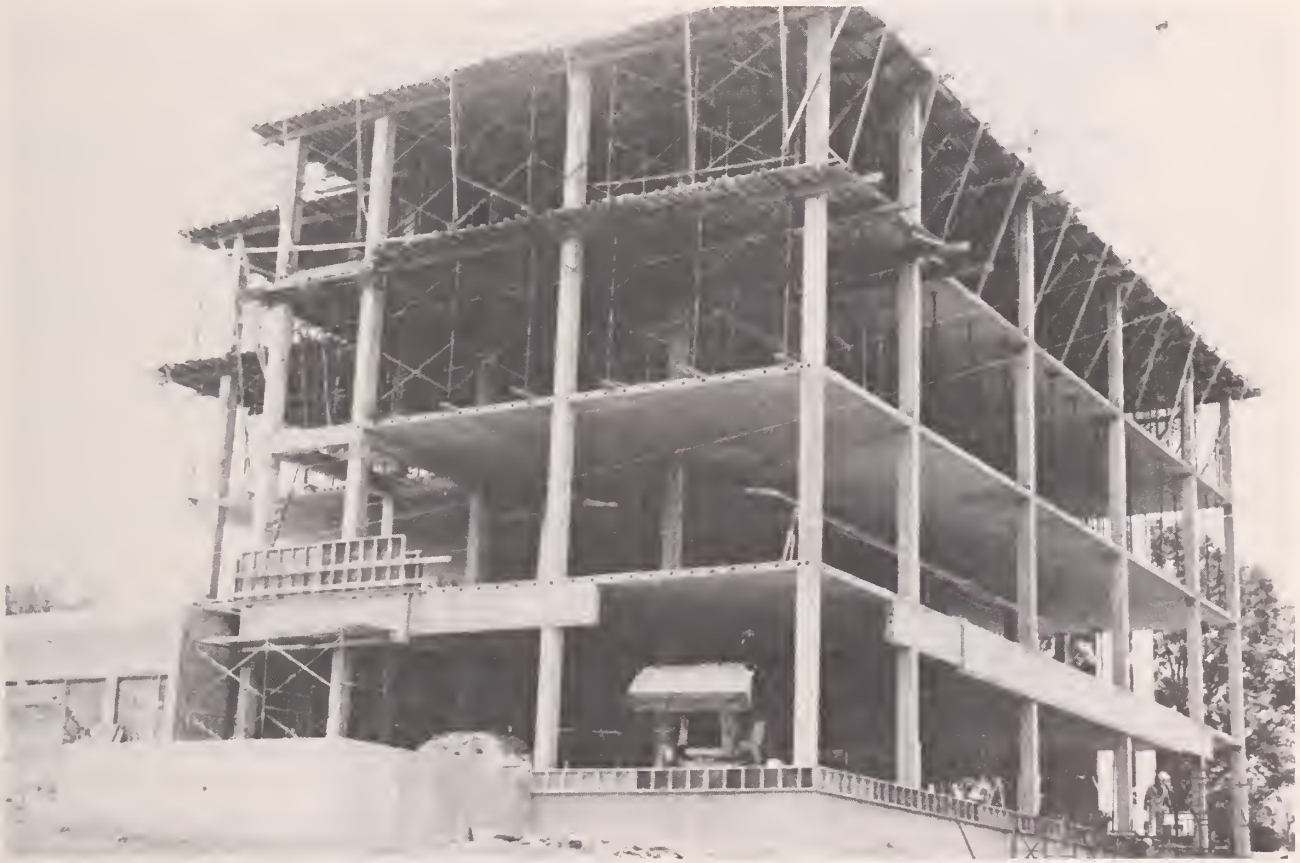
Among highlights of the meeting was a preliminary report from Physicians Health Plan (PHP) of Ohio giving an overview of recommendations the company will make with respect to organization of the MSMA sponsored HMO/IPA.

Among PHP's preliminary recommendations were that the HMO/IPA offer a multi-line of products to include IPA, PPO and indemnity products and that the initial HMO/IPA organizational boards be streamlined into a business entity.

The Board of Trustees acted on the latter recommendation by reducing the 41-member HMO/IPA boards to ten members and urging non-reappointed board members to continue to serve on important HMO/IPA committees such as quality assurance and utilization review.

The reappointed HMO/IPA boards will receive PHP's full management report in September. Members of the board are Drs. William Gates, Columbus; Stanley Hartness, Kosciusko; Bob Graham, Meridian; Wade Dowell, Indianola; Roy Duncan, Pascagoula; Gerald Jackson, Hattiesburg; David Steckler, Natchez; and Robert A. Smith, F. Earl Fyke, Jr., and Lamar Weems, Jackson.

The Board of Trustees also heard a report on tort reform efforts to include activities presently being conducted by a committee of the association meeting with representatives of the Mississippi Trial Lawyers Association. The board stated its intent to make tort reform a priority legislative item in the 1987 Mississippi Legislature and to seek the support of all MSMA members in this effort.



This was the scene at 735 Riverside Drive in August, as construction continued on MSMA's new headquarters. The four-story addition to the existing building (visible in left foreground) will be ready for occupancy next spring.

The board also acted to contract with the AMA and Medical Payment System, Inc. to have MSMA Services be the state franchise for a new electronic medical billing system to be offered to MSMA members. Mississippi will be one of the first states to implement the nationwide billing system which will both electronically submit bills to third party payors and direct bill patients.

The board received a report on a program titled "Operation Lookback" which is directed at notifying recipients of units of blood and blood products previously donated by donors who now have a confirmed positive test for antibody to HTLV-III. The board directed that the association join in a cooperative effort with the Mississippi Hospital Association, State Department of Health and the blood banking community to implement "Operation Lookback" in Mississippi.



In other actions the Board of Trustees:

— Enacted a program to encourage each MSMA component society to send a representative to the annual AMA Leadership Conference whose expenses would be reimbursed one-half by MSMA.

— Requested the Commissioner of Insurance to require insurance companies to indicate a pre-authorization or certification condition on policyholders' ID cards.

— Joined a coalition of state medical associations to inquire into and respond to changes in the CHAMPUS program.

— Directed that a letter be sent to each hospital chief-of-staff and administrator urging improved communication on all socioeconomic aspects of the local hospital.

— Restated the association's support for physician representation on hospital governing boards and directed that a letter be sent to all county supervisors indicating this support.

— Stated its support for the activities of the State Task Force on Health Education in the Public Schools and offered support for those activities.

— Directed that the data be gathered for the board to study and recommend a position on a proposed state law requiring employers to furnish health insurance to their employees.

— Restated the association's support for a compulsory seat belt law.

— Restated the association's position supporting a law to require a health insurance pool for high risk individuals.

— Directed that the association offer a legal review of contracts of alternative delivery systems as a membership service.

The following trustees and officers were in attendance at the August board meeting: David R. Steckler, M.D., chairman, Natchez; J. Edward Hill, M.D., vice chairman, Hollandale; David M. Owen, M.D., secretary, Hattiesburg; Stanley Hartness, M.D., Kosciusko; Lee H. Rogers, M.D., Tupelo; John P. Lee, M.D., Forest; Stanley A. Wade, Jr., M.D., Meridian; Roy D. Duncan, M.D., Pascagoula; W. Joseph Burnett, M.D., president, Oxford; Ralph L. Brock, M.D., immediate past president, McComb; Don Q. Mitchell, M.D., secretary-treasurer, Jackson; Carl G. Evers, M.D., speaker of the House, Jackson; and James C. Waites, M.D., vice speaker of the House, Laurel.

Ob-Gyn Endowment Advisory Committee Meets



Members of the University of Mississippi Medical Center Obstetrics and Gynecology Endowment Trust Advisory Committee who attended the biannual meeting in July were from left, Dr. Cecil Knox of Jackson; Dr. Winfred Wiser, UMC professor of obstetrics and gynecology and chairman of the department and of the committee; Dr. John Lindley of Meridian; and J. P. Mills of Tupelo. Earnings from the Trust are used to fund research and research development in the Department of Obstetrics and Gynecology. Other committee members are Dr. William Cleland of Jackson; Dr. P. K. Thomas of Tupelo; Dr. Jack Hoover of Pascagoula; and Dr. E. J. Price of McComb.

Six Join Faculty At Medical Center

Six have been named in medical, nursing, dental, health related professions and centerwide faculty appointments and promotions at the University of Mississippi Medical Center for the coming academic session.

The faculty were announced by Dr. Norman C. Nelson, vice chancellor for health affairs, following approval by the Board of Trustees of State Institutions of Higher Learning.

In the School of Medicine, Dr. Helen Barnes, associate professor of obstetrics and gynecology, was named an assistant professor of family medicine.

Ada M. Seltzer was named director of the Rowland Medical Library in appointments centerwide. She succeeds Irene Graham who retired on June 30.

Dr. Barnes earned the A.B. at Hunter College and in 1958, received the M.D. from Howard University in Washington, D.C. She did her internship and residency at Kings County Hospital in Brooklyn, N.Y. Before coming to the Medical Center in 1969, she was assistant professor of obstetrics and gynecology at Tufts University, and a staff physician at Mound Bayou Community Hospital at the Tufts-Delta Health Center.

Ms. Seltzer earned the B.S. in 1964 at the Kutztown University of Pennsylvania, the M.S. in 1965 at Florida State University and the M.A. in 1971 at the University of South Florida. She was assistant librarian for the University Library at the University of South Florida from 1965-1968, and associate librarian from 1969-1971. She also served as the university librarian for the USF Medical Center Library from 1971-1974 and as head of public services from 1974-1979. Since that time she has served as assistant director of public services for the Medical Center Library and as visiting instructor for the School of Library Studies at USF.

Other appointments to the Medical Center faculty were in the School of Nursing, Edith E. Anderson, instructor in nursing; in the School of Health Related Professions, Jean A. Tannerhill, instructor in respiratory therapy; and in the dental school, Dr. Judith T. Buchanan was promoted to associate professor of restorative dentistry and Dr. Harold E. Grupe, Jr., associate professor of periodontics and chairman of the department, was named acting dean of the school.

POSTGRADUATE CALENDAR

October

The Heart Patient With Anxiety: Contributions from Cardiology and Psychiatry
Oct. 24
Ramada Renaissance Hotel, Jackson

Charles E. Culpeper Foundation Visiting Professor
Oct. 12-15
University Medical Center, Jackson

November

Seventh Annual Communicative Disorders Symposium and Godfrey Arnold Lecture
Nov. 7-8
University Medical Center, Jackson

Epilepsy for Physicians 1986
Nov. 20
Deerfield Country Club, Madison

Pediatric Annual Meeting
Nov. 21-22
University Medical Center and Sheraton Regency Hotel, Jackson

December

Eighth Annual Mississippi Perinatal Postgraduate Course
Dec. 11-12
Ramada Renaissance Hotel, Jackson

For more information or a program brochure, contact the University Medical Center Division of Continuing Health Professional Education, the University of Mississippi Medical Center, 2500 North State Street, Jackson, Mississippi 39216-4505; or call (601) 984-1300.

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NEW MEMBERS

BRIDGES, WILLIAM D., Pascagoula. Born McComb, MS, Feb. 5, 1933; M.D., University of Mississippi School of Medicine, Jackson, 1962; one year internship, East Tennessee State Hospital, Nashville, 1962-63; elected by Singing River Medical Society.

BRUCKMEIER, KURT F., Hattiesburg. Born Birmingham, AL, May 9, 1956; M.D., University of Mississippi School of Medicine, Jackson, 1982; interned and medicine residency, University Medical Center, Jackson, 1982-85; elected by South Mississippi Medical Society.

CROSBY, SAMUEL NEIL, Hattiesburg. Born Laurel, MS, Dec. 3, 1957; M.D., University of Mississippi School of Medicine, Jackson, 1983; interned and family practice residency, Jackson-Madison County General Hospital, Jackson, TN, 1983-86; elected by South Mississippi Medical Society.

DEVABHAKTUNI, PRAMODA K., Jackson. Born India July 15, 1952; M.D. Lady Hardinge Medical College, New Delhi, Delhi, India 1980; interned and medicine residency, University Medical Center, Jackson, MS, 1982-85; elected by Central Medical Society.

FOLK, BEN P., III, Greenville. Born Jackson, MS, Oct. 17, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1981; medicine residency, Vanderbilt University Hospital, Nashville, TN, 1981-84; cardiology residency, same, 1984-86; elected by Delta Medical Society.

GILLESPIE, DOROTHY, Hattiesburg. Born Raeford, NC, Oct. 26, 1949; M.D., George Washington University School of Medicine, Washington, DC, 1975; interned and medicine residency, Misericordia Hospital, Bronx, NY, 1975-78; elected by South Mississippi Medical Society.

GILLESPIE, HILTON L., JR., Hattiesburg. Born Augusta, GA, Jan. 5, 1957; M.D., University of Mississippi School of Medicine, Jackson, 1982; interned and ob-gyn residency, University of Alabama School of Medicine Hospital, Birmingham, 1982-86; elected by South Mississippi Medical Society.

HAYLES, KENNETH J., Greenville. Born Birmingham, AL, Feb. 3, 1949; M.D., Far Eastern University, Manila, Philippines, 1977; one year residency and ophthalmology residency, Oschsner Medical Foundation Hospital, New Orleans, 1978-82; elected by Delta Medical Society.

JEKOT, JEFFREY M., Hattiesburg. Born Dallas, TX, June 21, 1957; M.D., University of Texas Medical Branch, Galveston, 1983; anesthesiology residency, University of Texas, Galveston, 1983-86; elected by South Mississippi Medical Society.

KAHLER, RALPH C., Hattiesburg. Born Hattiesburg, MS, Dec. 1, 1955; M.D., University of Mississippi School of Medicine, Jackson, 1981; interned, medicine residency and infectious disease residency, University Medical Center, Jackson, 1981-84; elected by South Mississippi Medical Society.

LOWRIMORE, MARLIN G., Hattiesburg. Born Laurel, MS, Aug. 31, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned, one year, University Medical Center, Jackson; medicine residency, Baptist Memorial Hospital, Memphis, TN, 1981-83; cardiology fellowship, Texas Heart Institute/St. Luke's Episcopal Hospital, Baylor College of Medicine, Houston, TX, 1983-85; elected by South Mississippi Medical Society.

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NEW MEMBERS/Continued

LUCIANO, VICENTE CO., Ruleville. Born Philippines, March 17, 1940; M.D., University of St. Tomas, Philippines, 1964; interned Ravenswood Hospital, Chicago, one year; radiology residency, Weiss Memorial Hospital and Mercy Hospital, Chicago, 1967-70; elected by Delta Medical Society.

LYONS, ALFRED G., Hattiesburg. Born Biloxi, MS, June 27, 1957; M.D., University of Mississippi School of Medicine, Jackson, 1983; anesthesiology residency, University of Texas Medical Branch, Galveston, 1983-86; elected by South Mississippi Medical Society.

MARTIN, SHERRY A., Hattiesburg. Born Laredo, TX, Sept. 25, 1957; M.D., University of Mississippi School of Medicine, Jackson, 1982; interned and medicine residency, North Carolina Memorial Hospital, Chapel Hill, NC 1982-85; elected by South Mississippi Medical Society.

RIGDON, EDWARD E., Laurel. Born Union, MS, Aug. 4, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned University of Alabama, Birmingham, one year; surgery residency, University Medical Center, Jackson, MS, 1979-84; elected by South Mississippi Medical Society.

SCHNEIDER, JOSEPH F., JR., Meridian. Born Philadelphia, PA, Dec. 29, 1942; M.D., University of Alabama School of Medicine, Birmingham, 1981; interned, one year, Lloyd Noland Hospital, Fairfield, AL; radiology residency, Harvard Medical School, Boston, 1982-86; elected by East Mississippi Medical Society.

TUCCI, JAMES MICHAEL, Hattiesburg. Born Teaneck, NJ, July 31, 1949; M.D. Rutgers Medical School, New Brunswick, NJ 1978; interned and neurology residency National Naval Medical Center, Bethesda, MD, 1978-82; elected by South Mississippi Medical Society.

WARRINGTON, JAMES E., JR., Clarksdale. Born Jackson, MS, Oct. 21, 1957; D.O., Southeastern College of Osteopathic Medicine, Miami Beach, 1985; one year internship, same; elected by Clarksdale and Six Counties Medical Society.

WEAVER, JASON MICHAEL, Hattiesburg. Born Columbus, GA, Sept. 29, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned and orthopedic surgery residency, University Medical Center, Jackson, 1980-85; elected by South Mississippi Medical Society.

WILLIAMS, ROBERT LYNN, JR., Biloxi. Born Miami, FL, Jan. 27, 1944; M.D., University of Florida College of Medicine, Gainesville, 1971; interned, pediatric residency, and pediatric nephrology fellowship, University of Florida, Gainesville, 1971-78; elected by Coast Counties Medical Society.

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DEATHS

GREEN, GEORGE W., JR., Benoit. Born Aug. 27, 1917; M.D., University of Tennessee College of Medicine, Memphis, 1944; died Aug. 11, 1986, age 69.

KOUMJIAN, KEVIN J., Ashland. Born Ft. Huachuca, AZ, April 1, 1957; M.D., University of California School of Medicine, San Francisco, 1983; interned, one year, San Francisco General Hospital; died Aug. 29, 1986, age 29.



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All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus*, volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made.

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In addition, in view of *The Copyright Revision Act of 1976*, effective Jan. 1, 1978, transmittal letters to the editor should contain the following language: "In consideration of the Mississippi State Medical Association's taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the MSMA in the event that such work is published by the MSMA." We regret that transmittal letters not containing the foregoing language signed by *all* authors of the submission will necessitate delay in review of the manuscript. — *The Editors.*

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J-6138 January 1986

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* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: **Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired.** If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

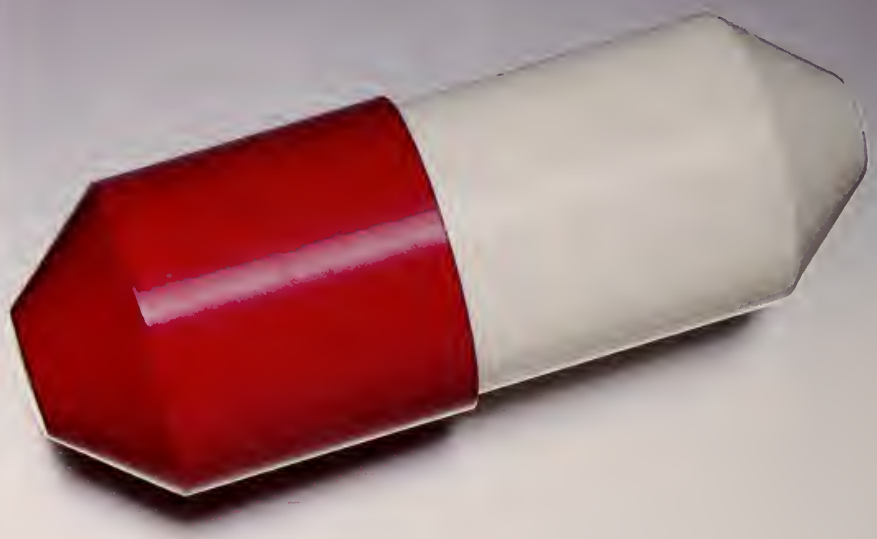
Supplied: **'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.**

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MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 21-25, 1987, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

State and Local

Mississippi State Medical Association, 119th Annual Session, June 3-7, 1987, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, July 29-August 1, 1987, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, February, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, January, May, and November. H. S. Barrett, Secy., P.O. Box 1810, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington, Yazoo.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, Secy., Mail: Ms. Jenkins, P.O. Box 4053, Meridian 39305. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, Meetings scheduled quarterly. Fred G. Emrich, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, January. Charles S. Watras, 612 Summit St., Winona 38967. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, September, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. William Billington, Secy., 731 Medical Center Dr., West Point, MS 39773. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 1st Wednesday, February, April, June, August, October, December. John J. McCloskey, Secy., 3003 Short Cut Rd., Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. George R. Bush, Secy., 307 S. 13th Ave., Laurel 39440. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly
Mississippi State Medical Association
735 Riverside Drive
Jackson, MS 39216

North Mississippi Medical Center
830 Gloster Avenue
Tupelo, MS 38801

Forrest General Hospital
Box 1897
Hattiesburg, MS 39401

Mississippi Baptist Hospital
1225 N. State Street
Jackson, MS 39201

Gulf Coast Community Hospital
4642 W. Beach Boulevard
Biloxi, MS 39531

Jefferson Davis Memorial Hospital
Box 1488
Natchez, MS 39120

King's Daughter Hospital
Box 948
Brookhaven, MS 39601

Riverside Hospital
Lakeland Drive
Jackson, MS 39208

Biloxi Regional Medical Center
1559 Lafayette St.
Biloxi, MS 39533

Jeff Anderson Regional Medical Center
2124 14th St.
Meridian, MS 39301

Northwest Mississippi Regional Medical Center
Box 1218
Clarksdale, MS 38614

Mississippi Chapter
American College of Surgeons
Box 5229
Jackson, MS 39216

North Panola County Hospital
Drawer 160
Sardis, MS 38666

Singing River Hospital
P.O. Box 112
Pascagoula, MS 39567

Magnolia Hospital
Alcorn Drive
Corinth, MS 38834

Greenwood Leflore Hospital
1508 Leflore Avenue
Greenwood, MS 38930

Gulfport Memorial Hospital
4500 13th Street
Gulfport, MS 39501

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PERSONALS

WILLIAM O. BARNETT of Jackson was speaker at a meeting of ostomy patients at Methodist Hospital in Hattiesburg.

EDWARD J. BASS of Hattiesburg announces the association of KURT F. BRUCKMEIER for the practice of internal medicine.

CHARLES D. BORUM announces the opening of his office for the practice of family medicine at 212 Main Street in Natchez.

ARNOLD D. BRIDGES, JR. announces the opening of his office for the practice of internal medicine at 965 Avent Drive in Grenada.

SARAH J. BROOM has associated with The Medical Clinic, P.A., of Jackson, for the practice of pulmonary medicine and internal medicine.

JAMES L. BURKHALTER has associated with the Radiological Group, P.A., of Jackson, for the practice of diagnostic radiology.

CHING J. CHEN of UMC presented a paper at the International Ophthalmology Congress in Rome, Italy.

WEIR CONNER of Jackson presented a series of staff development in-service talks to teachers in Jackson and surrounding areas.

TOMMY J. CAMPBELL announces the opening of his clinic for the practice of internal medicine at 820 Oak Avenue in Ruleville.

BRYAN COWAN of UMC lectured at the North Mississippi Women's Health Center in Tupelo.

SAMUEL NEIL CROSBY has associated with Hattiesburg Clinic for the practice of family medicine.

LAURIE CYNTHIA CROWE announces the opening of her office for the practice of internal medicine at 346 Crossgates Boulevard in Brandon.

DAVID CRAWFORD of UMC was speaker at the American Urological Association meeting in New York and at a Trans Medical Symposium in Houston, Texas. He also spoke at the Second International Symposium on Prostatic Carcinoma in Paris.

J. T. DAVIS, JR. and MIKE LOVELACE announce the opening of their office at 2169 South Lamar in Oxford for the practice of cardiac, vascular, and thoracic surgery.

EDGAR DRAPER of UMC presented the Oskar Pfister Award at the annual meeting of the American Psychiatric Association in Washington, DC.

J. B. FRANKLIN and H. E. WOOD announce their association with Family Medical Clinic of Gulfport for the practice of internal medicine.

JOHN Y. GIBSON and EDWARD L. GIEGER, JR. of Jackson have been named fellows of the American College of Radiology.

JONATHAN HARRIS announces the opening of his office for the practice of internal medicine at 713 Desoto Avenue in Clarksdale.

EDGARDO C. HIDALGO announces the opening of his office for the practice of pediatrics at 302 Hospital Road in Fulton.

PLEASANT F. HOOPER has been named director of Garden Park Outpatient Clinic, 130 Fleitas Avenue in Gulfport.

JAMES HUGHES of UMC attended an executive committee meeting of AO-ASIF in Bern, Switzerland.

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PERSONALS/Continued

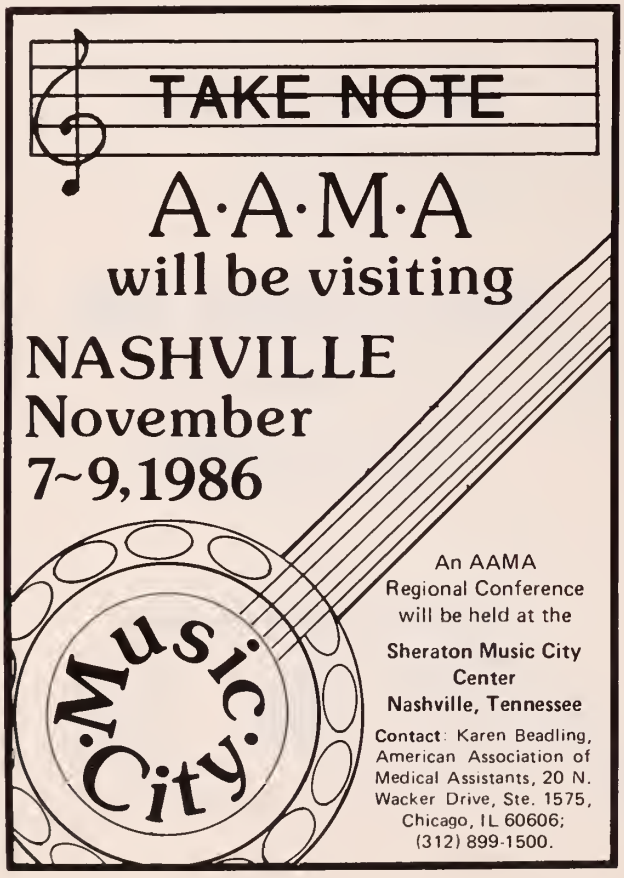
Leslie L. Jones and C. Stephen Perry announce the opening of their clinic for the practice of pediatrics at 415 Highway 51 South in Ridgeland.

William L. Kahlstorf of Tupelo spoke on osteoporosis at North Mississippi Women's Health Center in Tupelo.

Joel Martin Knight announces the opening of his office for the practice of ophthalmology at 127 Lameuse Street in Biloxi.

Herbert Langford of UMC spoke at a symposium on cardiovascular medicine in Chicago.

Eric Lindstrom of Laurel was speaker at the Laurel Kiwanis Club recently.



Connie McCaa of UMC conducted a seminar at the annual convention of the Opticians' Association of America in Nashville.

H. T. Milhorn of UMC presented a paper at the 1986 Louisiana Academy of Family Physicians meeting in Lafayette.

John Morrison of UMC attended an NIH committee meeting in Washington, DC.

Yoshinobu Namihira announces his association with Better Living Medical Clinic in Vicksburg for the practice of gastroenterology.

W. Thomas Oakes, Jr., announces the opening of his office for the practice of neurology at 609 Brunson Drive in Tupelo.

Mary E. Pace of Tupelo spoke on "Women and Smoking" at North Mississippi Women's Health Center in Tupelo.

J. S. Purdon announces the opening of his office for the practice of cardiology at 2169 South Lamar in Oxford.

Albin Steiner announces the opening of his practice of radiology in Houston.

James T. Trapp of Pontotoc has been named a fellow of the American College of Radiology.

Dexter Winn Walcott and Children's Clinic of Oxford announce the association of Joe T. Harris for the practice of pediatrics at 2200 South Lamar in Oxford.

W. Lamar Weems of UMC moderated a session at the annual meeting of the American Hospital Association in Toronto, Ontario, Canada.

Ralph P. Wells has associated with Jackson Radiology Associates, Hinds General Hospital, for the practice of radiology.

J. Lee Valentine has associated with Rush Medical Group for the practice of family medicine in Lake.

Ralph Vance of Jackson recently received the Tate Thigpen Award presented by the Central Mississippi Chapter of the American Red Cross.

Charles O. Williams has associated with the Radiological Group, P.A. for the practice of diagnostic radiology.

V. Frank Vogel of Gulfport presented a series of four lectures to the Psychiatry Services of the V.A. Medical Center of Gulfport.

10 YEARS

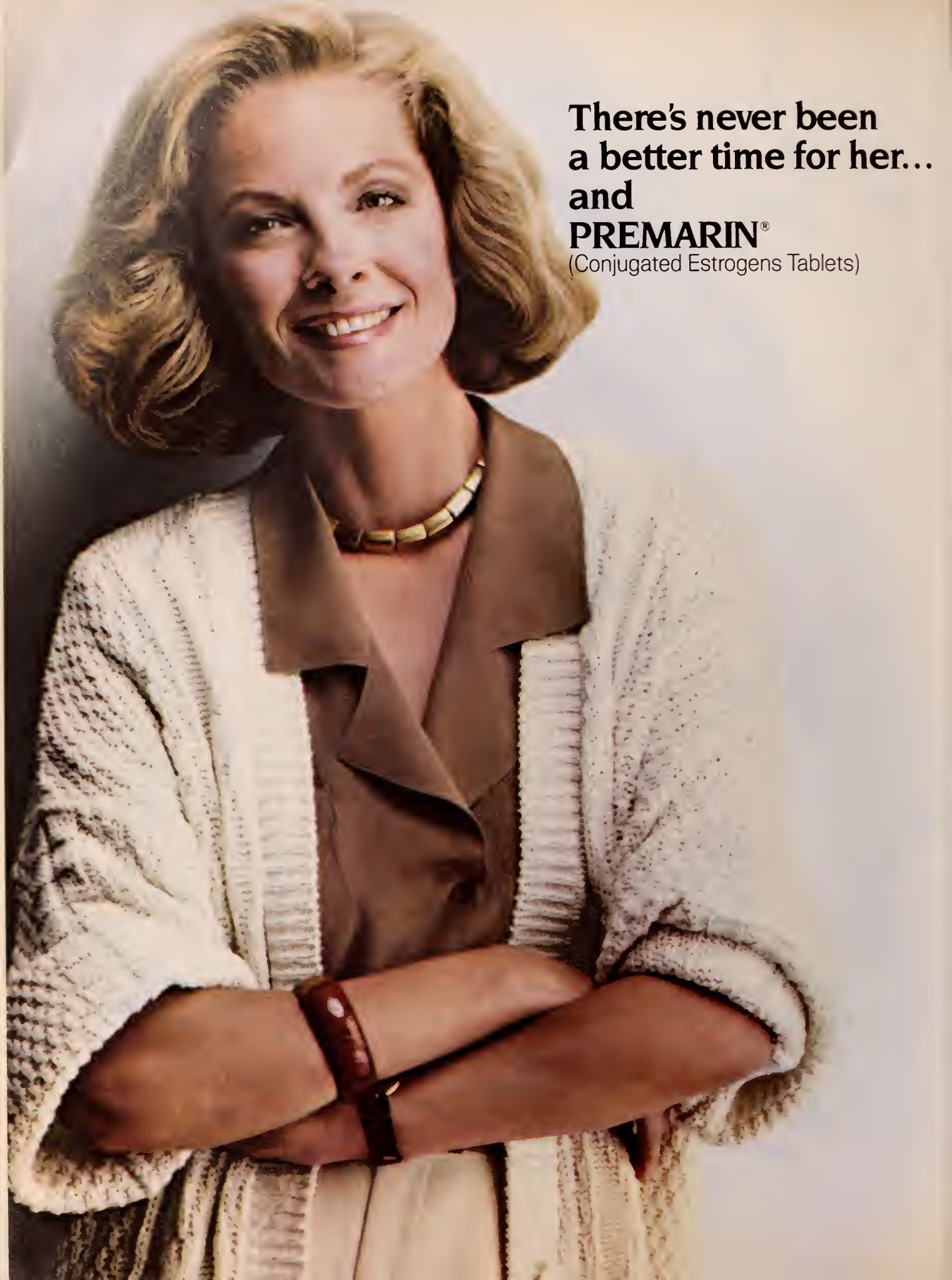
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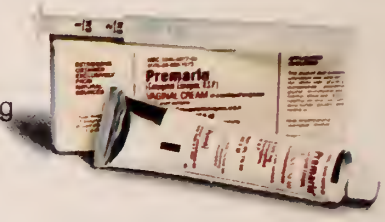
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PREMARIN® Brand of conjugated estrogens Vaginal Cream in a nonliquefying base

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA.

Three independent case control studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case control studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semiannual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equiestrogenic doses.

2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY.

The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a non-steroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb reduction defects. One case control study estimated a 4.7-fold increased risk of limb reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe *vasomotor* symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) **Osteoporosis (abnormally low bone mass).** Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae. PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (See Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. There are now reports that estrogens increase the risk of carcinoma of the endometrium in humans. (See Boxed Warning.) At the present time there is no satisfactory evidence that estrogens given to postmenopausal women increase the risk of cancer of the breast, although a recent study has raised this possibility. There is a need for caution in prescribing estrogens for women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Preexisting uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

a. Increased sulfobromophthalein retention.

b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.

c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG; free T4 concentration is unaltered.

d. Impaired glucose tolerance.

e. Decreased pregnanediol excretion.

f. Reduced response to metyrapone test.

g. Reduced serum folate concentration.

h. Increased serum triglyceride and phospholipid concentration. As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea; premenstrual-like syndrome; amenorrhea during and after treatment; increase in size of uterine fibromyomata; vaginal candidiasis, change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria; edema; changes in libido.

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females.

DOSAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only.* For treatment of moderate to severe *vasomotor* symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. *Given cyclically:* Female castration. Osteoporosis. Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Osteoporosis —0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off).

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only. For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three-to-six month intervals.

Usual dosage range: 2 to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

References:

1. Whitehead MI, Townsend PT, Pryse-Davies J, et al: Effects of estrogens and progestins on the biochemistry and morphology of the postmenopausal endometrium. *N Engl J Med* 1981;305:1599-1605. **2.** Paterson MEL, Wade-Evans T, Sturdee DW, et al: Endometrial disease after treatment with oestrogens and progestogens in the climacteric. *Br Med J* 1980;280:822-824. **3.** Magos AL, Brincat M, Studd JWW, et al: Amenorrhea and endometrial atrophy with continuous oral estrogen and progestogen therapy in postmenopausal women. *Obstet Gynecol* 1985, 67: 496-499. **4.** Whitehead MI, Lane G, Siddle N, et al: Avoidance of endometrial hyperstimulation in estrogen-treated postmenopausal women. *Semin Reprod Endocrinol* 1983;1:1;41-52. **5.** Barnes RB, Roy S, Lobo RA: Comparison of lipid and androgen levels after conjugated estrogen or depo-medroxyprogesterone acetate treatment in postmenopausal women. *Obstet Gynecol* 1985,66:216-219.

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Medico-Legal Brief

(Continued from page 276)

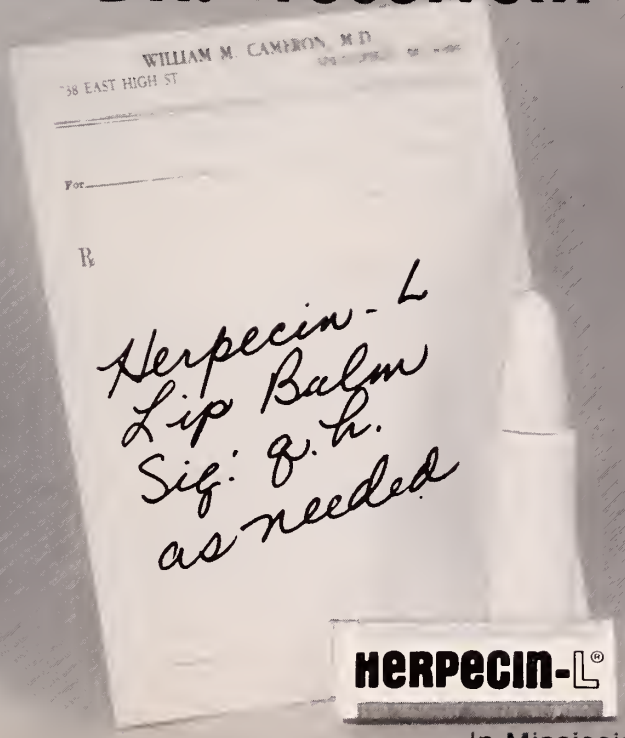
parental, physician, and community involvement — as opposed to heavy-handed Federal intervention — in the difficult decisions regarding treatment of severely impaired infants. The government had issued regulations which set up an elaborate mechanism in hospitals to generate reports about discrimination against handicapped infants, including "hot lines," intimidating notices, on-site investigations, and patient and hospital records production. The Court found no evidence of any discrimination and struck down the regulations. The Court concluded with the finding that Section 504 of the Rehabilitation Act "does not authorize the Secretary to give unsolicited advice either to parents, to hospitals, or to state officials who are faced with difficult treatment decisions concerning handicapped children."

The Court ruled against an association of dentists in *FTC v. Indiana Federation of Dentists* who mistakenly believed that by simply declaring themselves a "union" they could avoid the antitrust laws and collectively refuse to comply with insurance company cost containment programs. However, in accordance with views we expressed, the Court did *not* foreclose appropriate consideration of ethical and quality of care considerations in Federal antitrust actions.

We expressed no opinion with regard to the underlying merits of the abortion controversy in *Thornburgh, et al. v. American College of Obstetricians and Gynecologists, Pennsylvania Section, et al.*, but we did inform the Court in that case of the nature and importance of the physician/patient relationship in all medical treatment matters. The Pennsylvania statute at issue placed substantial, nonmedical informational, reporting and treatment burdens on physicians, even in cases where pregnancy endangered the life of the woman. The Court struck down the statute, concluding that: "All this is, or comes close to being, state medicine imposed upon the woman, not the professional medical guidance she seeks, and it officially structures — as it obviously was intended to do — the dialogue between the woman and her physician."

We are gratified with the results in these cases. The cases also may well serve as useful precedent in protecting physician autonomy in contexts other than that in which they arose. In the next issue, I will discuss the other three Supreme Court Cases AMA has been involved in.

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EMERGENCY ROOM physician needed to staff recently expanded emergency room coverage. Salary negotiable. Small town. 44-bed hospital approved for federal programs, located in central Mississippi. Contact Paul W. Strode, Box 428, Forest, MS 39074.

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The Mississippi Disability Determination Services now has a program available for medical society meetings and hospital staff meetings. The purpose of this program is to explain the Social Security Disability program, the medical documentation requirements, and how the disability determination process works. Any group interested in this presentation should also contact the Medical Relations Office.

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EMERGENCY MEDICINE and FAMILY MEDICINE positions available. Full-time positions available in hospital emergency departments and clinics. Prefer residency-trained or experienced physicians. Career opportunities available in central and south Mississippi. Attractive salary and benefit package. MEA, P.A. is a physician-owned and managed medical group committed to the financial security and personal development of each physician member. For information, contact: Sheila M. Lunceford; P.O. Box 12917, Jackson, MS 39236-2917; or call (601) 366-6503.

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Index to Advertisers

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..... **6A, 6B, 6C, 6D,** 288B, 288C, 288D

Bryant Galleries 276

Campbell Laboratories 289
Canton Exchange Bank 287
Curtis 1000 Information Systems 262

Disability Determination Services 290

Forrest General Hospital **4**

Harreld Chevrolet-Oldsmobile 281

Glaxo **10A, 10B, 10C, 10D**

Eli Lilly and Company **10**

Medical Assurance Co. of Miss. **8**
Miss. Baptist Medical Center **2**
MSMA Benefit Plan and Trust **12**

Premier Printing 265

Roche Laboratories ..... **third, fourth covers**

St. Dominic/Jackson Memorial Hospital 286
Stuart-James 282
Smith Kline and French..... 284B, 288A

U. S. Army 11

Jon Wimbish **6**
James Wooldridge 280

Thomas Yates & Co. **14**



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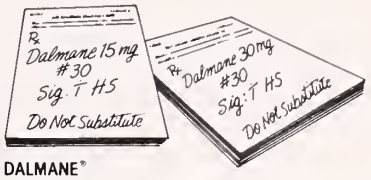
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Precoutions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reoctions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosoge: Individualize for maximum beneficial effect. *Adults*: 30 mg usual dosage, 15 mg may suffice in some patients. *Elderly or debilitated patients*: 15 mg recommended initially until response is determined.

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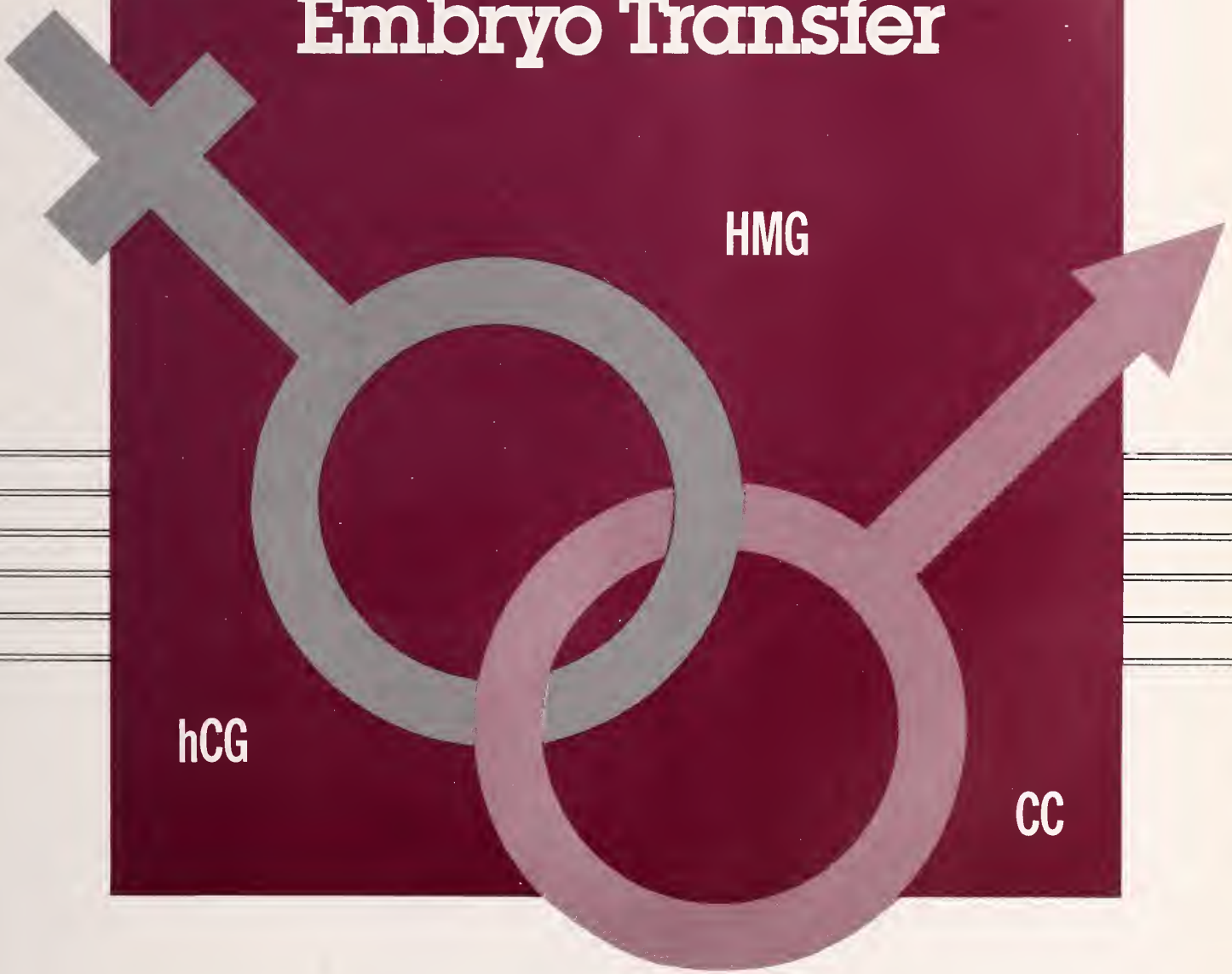
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November 1986

JOURNAL of the MISSISSIPPI State Medical Association

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CONTENTS

ORIGINAL PAPERS

The University of Mississippi Program of Human In-Vitro Fertilization and Embryo Transfer — **291** Bryan D. Cowan, M.D., John A. Lucas, M.D., Victoria M. Sopelak, Ph.D., G. Rodney Meeks, M.D., Neil S. Whitworth, Ph.D., G. William Bates, M.D., Gail Cravens, R.N., Carolyn Parks, R.N., and Winfred L. Wiser, M.D.

Tinea Unguium — **295** C. Ralph Daniel, III, M.D.

Inguinal Apocrine Gland Adenocarcinoma: Case Report — **299** Richard J. Field, III, M.D., David C. Mayer, M.D., and Richard J. Field, Jr., M.D.

EDITORIAL

High Finance — **303** Joseph E. Johnston, M.D.

THIS MONTH

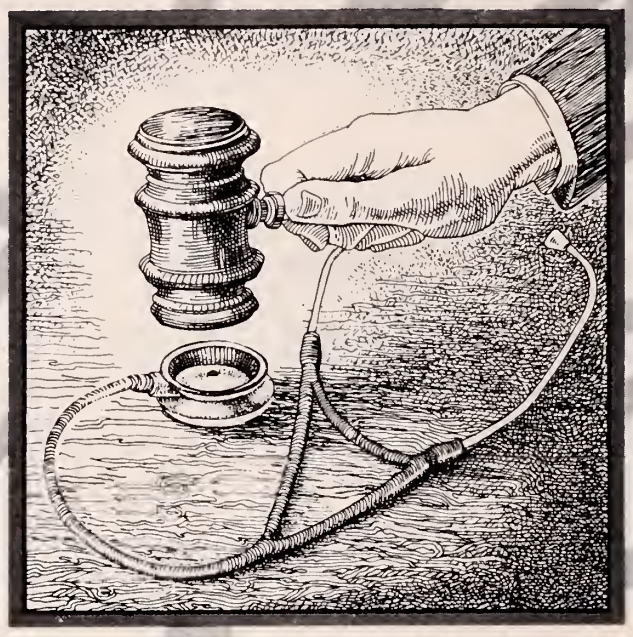
Community Service — **302** The President Speaking
303 Letters
305 Medical Organization
304 Medico-Legal Brief
310 Personals

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NEWSLETTER

November 1986

Dear Doctor:

More than a quarter of today's practicing physicians involved in patient care are opting to work for an employer rather than practice independently, according to a report by the AMA's Center for Health Policy Research. The report is based on a nationwide sample of 6,455 practicing physicians.

> Employee physicians grew from 23.4 percent of the nation's total in 1983 to 25.7 percent in 1985. Of these, 9.7 percent were hospital employees, 2.7 percent government employees, and 13.3 percent employees in other settings such as HMOs/IPAs and group practices. The employee physician's average 1985 income was $38,000 less than that of the self-employed doctor. The self-employed physician worked one-and-a-half more weeks per year than the employee physician, spent six more hours per week on patient care duties, and saw 19 more patients weekly. The percentage of employee physicians is sharply higher in the under-36 age group (47 percent) and among female physicians (45.5 percent).

More than 100,000 calls have been received at the toll-free helpline of the National Eye Care Project, a public service program providing medical eye care for older Americans. Of the 66,200 callers who have been referred to participating physicians, more than 16,000 have been treated for sight-threatening diseases. The Mississippi Eye, Ear, Nose and Throat Association is participating in the project which is co-sponsored by the Foundation of the American Academy of Ophthalmology. Patients who do not have Medicare or other insurance receive care from volunteer ophthalmologists at no charge. For those who have coverage, participating physicians accept insurance as payment in full.

Reminder: Dues statements have been mailed to all MSMA members. Be sure to include your spouse's membership dues for MSMA Auxiliary.

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Patsy Silver

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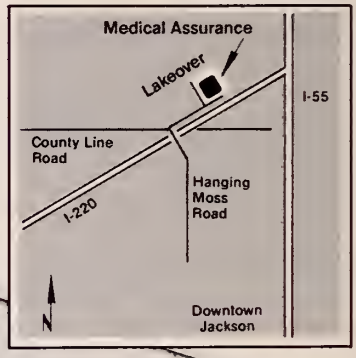
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DATELINE

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BC-BS Is Intermediary For Medicaid Program

Jackson, MS - Blue Cross-Blue Shield of Mississippi, Inc. becomes fiscal intermediary for the Mississippi Medicaid Program effective January 1. Blue Cross-Blue Shield, Medicaid, and the present intermediary (EDS) are preparing for a transfer of the program. Physicians' office personnel should be alert for upcoming announcements pertaining to the transition and for information about workshops.

Experimental AIDS Treatment Offered

Jackson, MS - Some physicians have received inquiries about a program providing the experimental drug AZT free to AIDS patients. Through an arrangement between Burroughs Wellcome, the National Institutes of Health, and the FDA, some 6,000 AIDS patients will receive the drug. A toll-free number (1-800-843-9388) has been established to handle applications and to provide information to physicians and patients.

Another AIDS Drug Is Being Developed

Atlanta, GA - A new drug under development appears to stop replication of AIDS virus at a level that does not harm uninfected cells. Scientists at Emory University, the University of Georgia and the Veterans Administration Medical Center, who synthesized the drug and are developing it for possible human trials, say CS-85 is at least ten times less toxic to human bone marrow than AZT.

Fish Oil May Help Psoriasis Patients

Chicago, IL - A study in the November Archives of Dermatology suggests that fish oil supplements might help psoriasis patients. Of 13 patients whose diets were supplemented with concentrated fish oil for two months, eight showed mild to moderate improvement. The researchers used no placebo-control group, and they note the study suggests the importance of further research in the role of polyunsaturated fatty acids in psoriasis.

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Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made.

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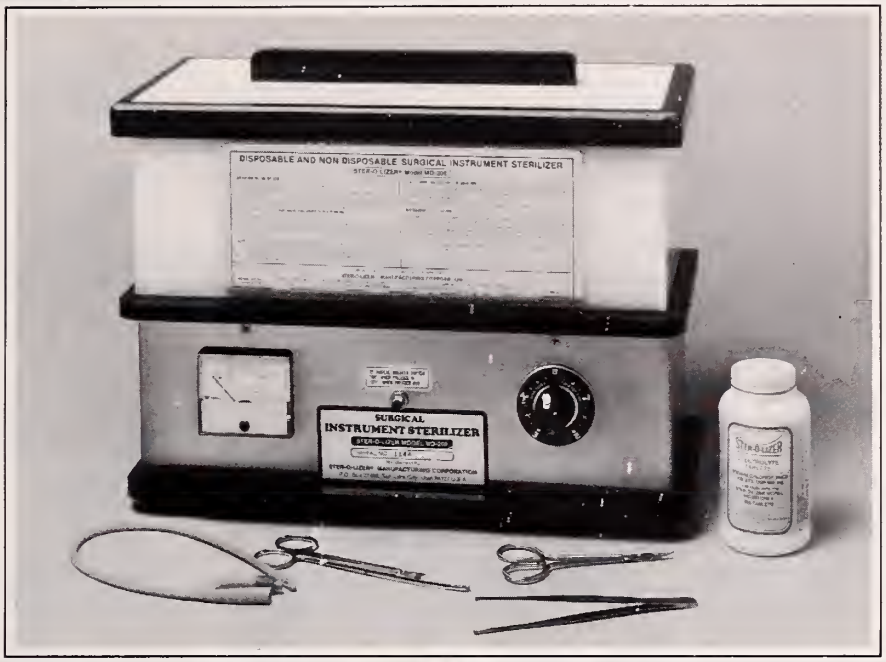
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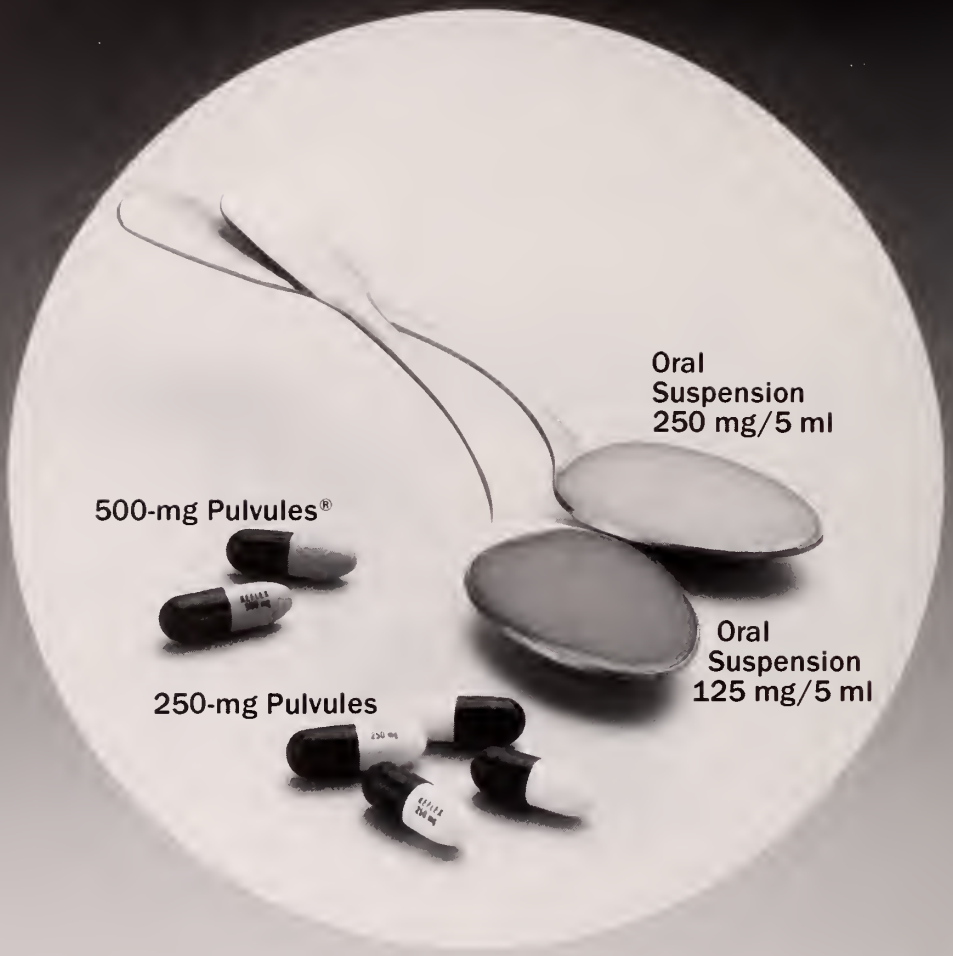
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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
November 1986, XXVII, Number 11

ORIGINAL PAPERS

The University of Mississippi Program of Human In-Vitro Fertilization and Embryo Transfer

BRYAN D. COWAN, M.D., JOHN A. LUCAS, M.D., VICTORIA M. SOPELAK, PH.D., G. RODNEY MEEKS, M.D., NEIL S. WHITWORTH, PH.D., G. WILLIAM BATES, M.D., GAIL CRAVENS, R.N., CAROLYN PARKS, R.N., and WINFRED L. WISER, M.D.
Jackson, Mississippi

A PROGRAM for *in-vitro* fertilization and embryo transfer (IVF-ET) was initiated at the University of Mississippi Medical Center in February 1984. This program was developed with major assistance from the Vicksburg Hospital Medical Foundation. The initiation of our program occurred six years after the birth of the first IVF-ET pregnancy, baby girl Louise Brown,[1] and three years after the first *in-vitro* fertilization birth in this country.[2] The goal of our program was to establish a successful program of IVF-ET for treatment of infertile couples. This report summarizes our experience during the period of February 1984 through June 1986 and reports the first live-born infant as a result of IVF-ET at the University of Mississippi Medical Center.

Materials and Methods

Patient Selection

Criteria for selection included documented infertility, the presence of a least one functioning ovary, and the presence of a normal uterus. The majority of infertile couples undergoing treatment by IVF-ET in our program had tubal disease. No patient was refused treatment because of age.

From the Department of Obstetrics and Gynecology, University of Mississippi Medical Center, Jackson, MS.

Multiple Follicular Development

All patients received follicular stimulation with human menopausal gonadotropin (HMG) with or without clomiphene citrate (CC). We currently administer CC 50 mg for five days beginning on day 2 of the cycle and begin HMG injections (150 IU) on day 3 or 4 of the cycle. Serum estradiol concentrations and pelvic ultrasonography are used to monitor follicular response. Monitoring begins on day 6-7 of the treatment cycle, and HMG is administered daily until three or more follicles greater than 14 mm have been visualized with ultrasonography, and the serum estradiol is greater than 1000 pg/ml. After the above follicular maturation has been effected, ovulation is triggered with 10,000 IU human chorionic gonadotropin (hCG). Laparoscopy for egg recovery is performed 34 hours after hCG administration.

Case Report — First IVF-ET Pregnancy at UMC

Our first successfully established pregnancy from IVF-ET at the University of Mississippi occurred in a 29-year-old caucasian G1, PO, A1 who previously had a right salpingectomy for a ruptured tubal pregnancy. The left tube was a hydrosalpinx. Follicular development was accomplished with a

combination of CC and HMG. Clomiphene citrate 50 mg was administered daily for five days beginnings on day 2 of the cycle and HMG 150 IU was administered daily beginning on day 4 of the cycle. On day 10, follicular ultrasonography revealed four follicles in the right ovary and two follicles in the left ovary which were greater than 14 mm, and serum estradiol concentration was 1204 pg/ml. hCG (10,000 IU) was administered at 10^{p}, and laparoscopic-directed follicular aspiration was performed 34 hours later. At follicular aspiration five oocytes were retrieved. Three were judged to be mature, while two were intermediate in maturation based on granulosa cell-oocyte morphology.

Insemination of all five oocytes was performed 4 hours, 45 minutes after recovery, and the sperm concentration for insemination was 100,0000 sperm/cc. Twenty-four hours after insemination, the eggs were transferred to growth medium. Only three of the five oocytes demonstrated double pronuclear structures with two polar bodies, the earliest morphologic confirmation of fertilization. Forty-eight hours after insemination, three four-cell embryos were observed (see Figure 1). Trans-cervical transfer of all three embryos was performed 55 hours after egg recovery (50 hours after fertilization.

Serum progesterone was measured seven days after hCG administration (cycle day 17), and was 81 ng/ml. A serum pregnancy test on cycle day 24 was positive. A pelvic sonogram performed 31 days after hCG administration confirmed a single intrauterine gestational sac. The pregnancy was uncomplicated and culminated with the delivery of a 4200 g female at 39 weeks of gestation.



Figure 1. A human embryo (4 cells) prior to uterine transfer. The zona pellucida surrounds the 4 blastomeres, and a few small granulosa cells surround the embryo.

Results of IVF-ET at UMC

Table I summarizes patient enrollment from February 1984 until June 1986. Fifty-four patients initiated an IVF treatment cycle during this time interval and nine cycles were discontinued because of a spontaneous luteinizing hormone surge that occurred prior to hCG administration. Forty-five women underwent laparoscopy for egg recovery; eggs were not recoverable in two cases. Of the 43 cases in which one or more egg was recovered, 36 had fertilization of at least one egg and 28 cases showed continued embryonic development (cleavage). Transfer of embryos to the uterus in these 28 cases has resulted in seven pregnancies. Three liveborn infants have been delivered; one from a singleton pregnancy and two from a twin pregnancy. Four other pregnancies are currently ongoing.

Table II summarizes the sperm count and oocyte data for 43 couples in whom oocytes were recovered. All pregnancies occurred in couples where the sperm count was greater than 40 million sperm/cc. However, fertilization and cleavage of eggs was as likely to occur in our patients when semen counts were 20-40 million sperm cc as it was when counts were greater than 40 million/cc. Men with sperm counts less than 20 million/cc were unable to fertilize any of 17 eggs.

Discussion

Infertility affects greater than 10% of reproductive age couples in the United States today, and the proportion of subfecund couples is increasing annually. Major advances in the diagnosis and correction of infertility have occurred in the last two decades. IVF-ET is a recently developed treatment option available to infertile couples, and is simply a method of fertilizing the human egg by circumventing the fallopian tube. The clinical application of this procedure, however, requires controlled ovarian hyperstimulation, rigorous monitoring of follicular development, oocyte recovery coincident with maturation of the egg, meticulous gamete (both egg and sperm) manipulation *in-vitro*, and fastidious quality control of culture conditions.

Several hundred pregnancies have now been established by the world-wide efforts of approximately 200 IVF-ET programs. In the United States, 65 programs are registered with the American Fertility Society in Birmingham, Alabama, as of this writing. The impetus for the development of such a large number of programs lies chiefly with the recognition that despite major advances in the treatment of infertility, most women with tubal disease

TABLE I

IN VITRO FERTILIZATION-EMBRYO TRANSFER (IVF-ET) AT THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER FROM 2/84-6/86.

A.	Cycles started	54			
B.	LH surges	9	%A	=	16.7
C.	Laparoscopy	45	%A	=	83.3
D.	Cases with 1 or more oocytes	43	%C	=	95.5
E.	Cases with fertilization	36	%D	=	83.7
F.	Embryo transfer	28	%C	=	77.7
	Pregnancies	7	%C	=	15.6
	4 ongoing		%F	=	25.0
	2 delivered				
	3 live-born infants				
	1 miscarriage				

TABLE II

GAMETE AND EMBRYO DATA FROM 43 IVF-ET TREATMENT CYCLES IN WHICH EGGS WERE RECOVERED

Sperm Count (million/cc)	*Patients*	*No. Eggs*	*No. Fertilized*	*No. Cleaved*	*No. Pregnant*
< 20	4	17	0	0	0
20-40	5	16	8 (50%)	5 (63%)	0
> 40	34	128	80 (63%)	52 (65%)	7
	43	161	88 (55%)	57 (65%)	7

or advanced endometriosis remain infertile after treatment. In addition, many couples with infertility from low sperm counts, regretted sterilization, cervical factors, immunologic factors, or unrecognized causes have been successfully treated by IVF-ET.

After the first several programs of IVF-ET reported their experiences, it became apparent that prenancies from IVF-ET could be expected to occur in 10 out of 100 procedures. Since normal fecundity in healthy couples results in 17 pregancies in 100 couples per month, one can see that the success of IVF-ET compares quite favorably to the natural pregnancy occurrence rate. In fact, the expected pregnancy success of IVF-ET is presently near 50% after six treatment cycles. Our program has achieved an initial pregnancy success rate of 15.6% for all women who undergo oocyte retrival, and a 25.0% pregnancy success rate for couples in whom cleaving embryos are transferred to the uterus. All women who have undergone more than two procedures in our program have conceived.

Because of these encouraging results, we recommend IVF-ET as a viable alternative to women with tubal or peritoneal disease who have a poor prognosis of pregnancy with corrective pelvic surgery. We also offer IVF-ET as a treatment option for cervical factors, immunologic factors, unexplained infertility and relative oligospermia. IVF-ET has granted hope to hopelessly infertile couples and changed the emphasis of reproductive medicine and gynecology. As we strive to improve IVF-ET, new forms of effective therapy for infertile couples will emerge. Our future is with our children, and it is to them that we have the greatest debt and responsibility. ★★★

2500 North State Street (39216)

Acknowledgment

Supported in part by the Vicksburg Hospital Medical Foundation.

We thank Donna White, Pam Fryer and Susan Wann for manuscript preparation. We give special thanks to Julie Tomasin, Kimberly Smith, Lynn Claypool, Donna Barnes, Kay Sullivan and Nancy Olson for technical assistance.

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Tinea Unguium

C. RALPH DANIEL, III, M.D.
Jackson, Mississippi

Tinea unguium, a very common disorder, must be correctly diagnosed before involved therapy is instituted. The author maintains that patients are often treated incorrectly, and suggests a method for diagnosis and therapy.

ONYCHOMYCOSIS (FUNGUS INFECTION of the nails) is a common disorder. By far, the most common type of fungus to be a primary pathogen is the dermatophyte which may cause tinea unguium. This paper will discuss some of the important diagnostic and management aspects of tinea unguium.

Tinea unguium may be caused by a number of dermatophytes. Trichophyton rubrum and trichophyton mentagrophytes are by far the most common.[1, 2] The former commonly affects fingernails and toenails. The latter commonly affects toenails but less frequently affects fingernails.

Predisposing factors include tinea pedis, trauma to the nail unit by any means, frequent exposure to heat and moisture, immunosuppression by any means, diabetes mellitus, and aging, especially in male patients.

It is uncommon for children to have tinea unguium before puberty. Normally menstruating women manifest the disorder less commonly than their male counterparts, suggesting a possible hormonal protective effect.

Diagnosis

Correct diagnosis is extremely important for several reasons. First of all, psoriasis and trauma to the nails, etc. many commonly mimic tinea unguium. Next, the treatment of tinea unguium may take anywhere from several months to over a year, since nails grow relatively slowly. It is incorrect to subject the patient to medication with possible side effects, following laboratory tests, and office visits if the diagnosis is not secure.

It is important to do KOH's and fungus cultures on all patients that are to be treated for tinea unguium. This is time consuming but still mandatory. One often sees positive KOH's and negative cultures on the same nail, or vice versa, for several reasons. First of all, the KOH may be positive and the culture negative if the hyphae obtained are sterile, or if the particular media utilized are inhibiting the growth of dermatophytes. Mycosel media with chloramphenicol and cyclohexamide may inhibit the growth of certain dermatophytes or other pathogens. Plain Saboraud's agar may allow too many other organisms to grow which may mask the dermatophyte. Dermatophyte Test Media (DTM) has a red indicator supposedly specific for dermatophytes that not infrequently gives a false positive with nondermatophyte nail saprophytes. So, DTM should not be used for nail cultures. One should use Mycosel and plain Saboraud's agar. KOH's are often negative when cultures are positive due to missing the hyphae on the specimen viewed, not allowing the nail to hydrolyze long enough before viewing, and utilizing too large of pieces of nail. Multiple KOH's or cultures should be done before proclaiming that the patient does not have a fungus. Crumbling subungual nail debris in general yields the highest return of positive specimens in patients with tinea unguium. Only occasionally is the fungus on or near the surface of the nail plate, making superficial nail plate scrapings unrewarding in most circumstances. Nail biopsies with PAS stain may also be utilized in difficult cases. Nail micronizers may be used to prepare whole clippings or whole intact nail plates for KOH or culture.[3]

Involvement of one hand and both feet (nails and/or palm and soles) suggest the diagnosis of "one hand, two feet tinea." Interestingly, this disorder is almost always caused by trichophyton rubum and is usually recalcitrant to therapy.

Dr. Daniel is engaged in the private practice of dermatology in Jackson, MS.

Treatment*

After the diagnosis is secure, my initial approach to therapy is to evaluate the location and extent of involvement. Upper extremity involvement is often easier to treat with a higher cure rate than lower extremity involvement. The fewer nails involved, the better.

If only one or two nails are involved, I avulse them with standard techniques.[4] I have found that this greatly improves the efficacy of therapy. I then begin treating the patient with micronized griseofulvin. Griseofulvin is the drug of choice for treating dermatophytes and is active only against dermatophytes. For the average-sized adult, the starting dose is 500 mg twice a day with meals. Treatment time varies according to the clinical response. I see patients every two months while they are on therapy, as I monitor their progress.[2] Fingernail treatment takes an average of 4-6 months, and toenails take as long as 2-3 times this period. Treatment is continued at least 3-6 weeks after a clinical and laboratory cure is obtained.

With involvement of many nails, especially numerous toenails, therapy is more difficult. In my opinion in this case, nail removal is not indicated. Chemical avulsion with urea, etc., does not work in most circumstances. Laser therapy to remove nails has recently been tried, but no large studies have been published to date. Since the nail unit needs to be anesthetized in most cases before using laser removal, simple surgical removal is probably simpler and cheaper in the long run in most cases, and surgical avulsion doesn't leave fragments of nail or the proximal part of the nail intact, as laser removal often does. The future may show that laser removal may be the treatment of choice in a small minority of cases when surgical avulsion is contraindicated. So, when many nails are involved, the patient is informed of a poor prognosis. If the patient chooses to have treatment, I give them griseofulvin as outlined above with their full understanding of a higher relapse rate.

The physician needs to be well acquainted with griseofulvin before giving it to the patient for long periods of time, and further reading about the drug is recommended. Griseofulvin may interact with phenobarbital, coumadin, etc. Relative and absolute contraindications for usage include pregnancy, liver disease, porphyria, allergy to the drug, leukopenia, etc. Baseline and every two month determinations of white cell counts and liver function should be obtained while on the drug.

Ketoconazole (Nizoral) is also active against dermatophytes, but is not indicated for dermatophyte therapy by the FDA at this time, even though extensive testing has shown its efficacy to be similar to griseofulvin. Rare reports of liver deaths associated with the drug have dampened some of the prior enthusiasm for using the drug.

*Modified from Current Therapy[1]

Summary

Tinea unguium is a treatable disease in most cases. The diagnosis must be made secure by laboratory confirmation before committing the patient to therapy. The patient must be aware of the involved, prolonged nature of the treatment and that relapse may occur. The most common causes of treatment failure for this common disorder are incorrect initial diagnosis, incorrect doses of griseofulvin, stopping therapy prematurely, and failure to discuss with the patient the prolonged nature of the treatment, possible side effects, and relapse rate. ★★★

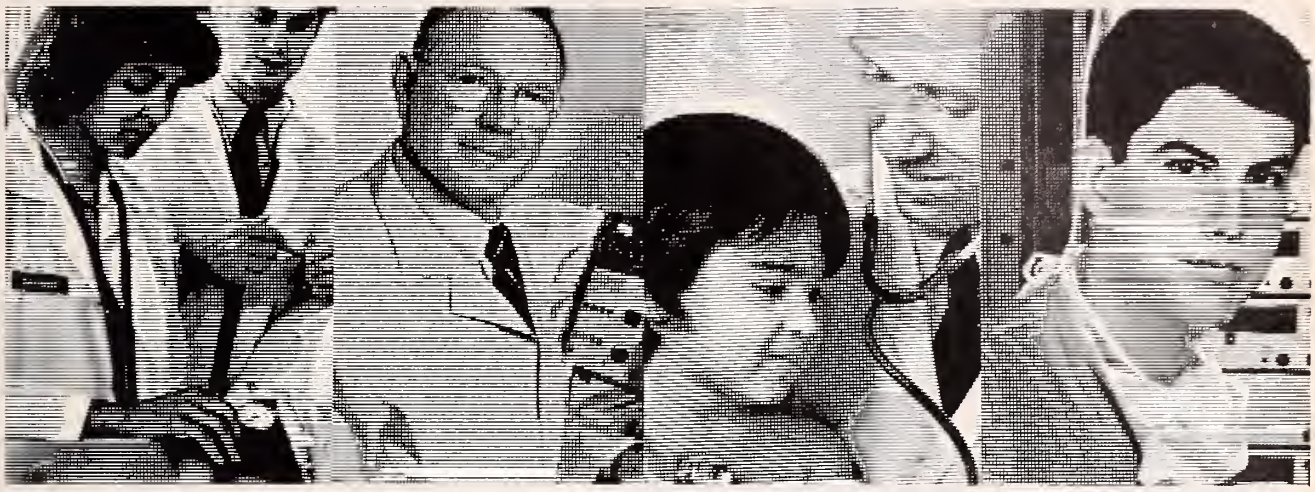
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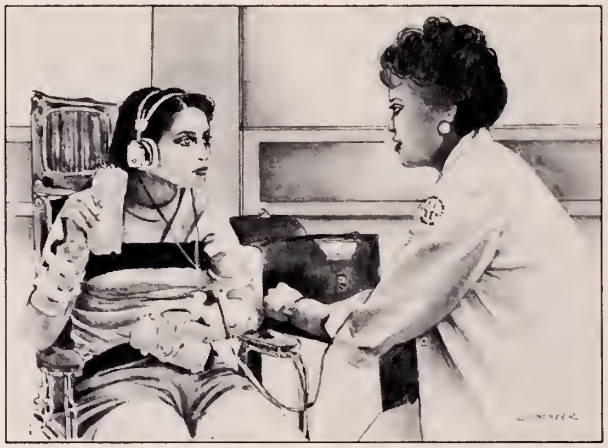
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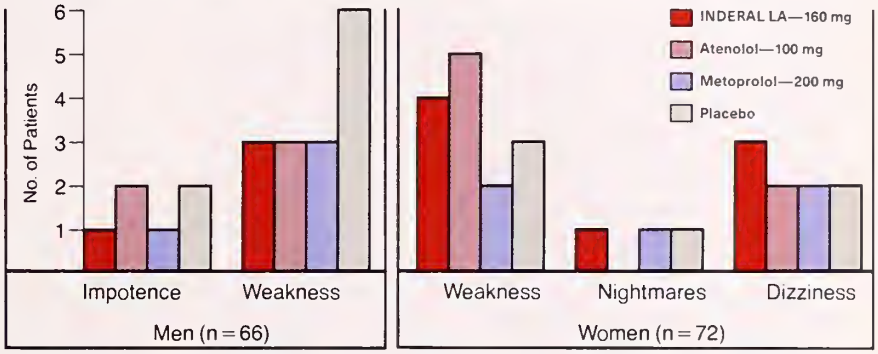
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CONTRAINDICATIONS

Propranolol hydrochloride (INDERAL® LA): Propranolol is contraindicated in: 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol.

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS

Propranolol hydrochloride (INDERAL® LA): CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated, and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely; or propranolol should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction following *abrupt* discontinuance of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution, since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS

Propranolol hydrochloride (INDERAL® LA): GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. Propranolol is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that propranolol may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs, such as reserpine, should be closely observed if propranolol is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies, in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose. There are no adequate and well-controlled studies in pregnant women. Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: Propranolol is excreted in human milk. Caution should be exercised when propranolol is administered to a nursing mother.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

Hydrochlorothiazide: GENERAL: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely: Hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs irrespective of cause are: Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect of digitalis (eg, increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content.

Any chloride deficit is generally mild and usually does not require specific treatment, except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism, such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

DRUG INTERACTIONS: Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

PREGNANCY: Pregnancy Category C. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnancy requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

NURSING MOTHERS: Thiazides appear in human milk. If use of the drug is deemed essential, the patient should stop nursing.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Propranolol hydrochloride (INDERAL® LA): Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia, congestive heart failure, intensification of AV block, hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability; slightly clouded sensorium; and decreased performance on neuropsychometrics.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation; mesenteric arterial thrombosis; ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash; fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis; nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia; LE-like reactions; psoriasiform rashes; dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

Hydrochlorothiazide:

Gastrointestinal: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation; jaundice (intrahepatic cholestatic jaundice); pancreatitis, sialadenitis.

Central Nervous System: Dizziness, vertigo; paresthesias, headache, xanthopsia.

Hematologic: Leukopenia; agranulocytosis, thrombocytopenia, aplastic anemia.

Cardiovascular: Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity: Purpura; photosensitivity, rash; urticaria; necrotizing angiitis (vasculitis, cutaneous vasculitis); fever; respiratory distress, including pneumonitis; anaphylactic reactions.

Other: Hyperglycemia, glycosuria; hyperuricemia, muscle spasm; weakness, restlessness; transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

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Inguinal Apocrine Gland Adenocarcinoma: Case Report

RICHARD J. FIELD, III, M.D.,
DAVID C. MAYER, M.D., and
RICHARD J. FIELD, JR., M.D.
Centreville, Mississippi

CARCINOMA OF APOCRINE GLAND origin is an uncommon tumor, and there is very little written about it. The lesion is rare enough that it is not described in most surgery and oncology texts. Herein, we present a typical case of this problem and we review our current knowledge on the topic.

Case Report

H. M. is a 82-year-old male who presented in March of 1985 complaining of a mass in his right inguinal area. He first noted the mass three years before seeking help. His medical history includes Type II diabetes mellitus, chronic obstructive pulmonary disease, and an inferior myocardial infarction. A transurethral prostatectomy was done eight years before presentation. A tentative diagnosis of squamous cell carcinoma was made and wide local excision was performed. The lesion was centrally located in the surgical specimen and had a diameter of 2.5 cm and a depth of 1 cm. A tissue diagnosis of adenocarcinoma of aprocrine gland origin was made. Surgical margins were free of tumor. No adjuvant chemotherapy or radiation treatment was considered at this time.

In March of 1986 the patient again presented with a lesion in his right inguinal area. He had noted this new growth more than six weeks before presentation. At this time there was a well healed surgical scar, but with two areas of ulceration present nearby. Wide local excision was again performed. The excised specimen had a small mass located in the subcutaneous tissue which was consistent with adenocarcinoma of aprocrine gland origin. There was extensive lymphatic and blood vessel involvement in the specimen. There was extension of the tumor past the deep margin and involvement of the femoral vessels. The patient is now undergoing radiation treatment to the right inguinal region.

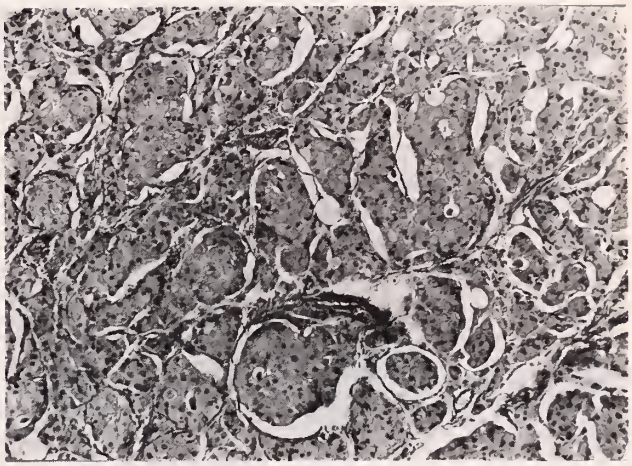


Figure 1. Photomicrograph of apocrine carcinoma with nests of eosinophilic tumor cells forming occasional lumina. (H&E, x 100).

Discussion

Apocrine cell carcinoma is a slow-growing, indolent tumor. The usual presentation is that of a painless mass which has slowly increased in size. Generally, it has not been present for over a year when the patient presents for evaluation. The lesion presents mostly in areas where apocrine glands are abundant. The axilla is the site more frequently involved. Other areas that have been reported include the inguinal, perianal, and perimammary regions. Frequently the skin overlying the tumor is intact with a red or purple color. Occasionally, skin ulceration is noted. Lesions usually appear in the sixth and seventh decades of life. To our knowledge, no

The authors are engaged in the private practice of surgery in Centreville, MS.

patient has presented with two or more primary apocrine gland cancers.

Apocrine glands are characterized by their method of secretion, whereby a part of the cytoplasm is pinched off from the rest of the cell (see Figure 1). This feature can be seen on some sections (microscopic) in many apocrine gland cancers. Histologically, a varying degree of differentiation has been noted. There is a correlation between higher degree of differentiation and higher survival rates, but this is not completely defined as of yet. These tumors are also characterized by large amounts of homogeneous cytoplasm.

To date, treatment for these lesions has been surgical excision. Lymph note dissection should be considered for more poorly differentiated tumors. Adjuvant chemotherapy and/or radiotherapy may be considered, but the advantages of these treatment modalities have not been determined.

Summary

Apocrine gland carcinoma is a rare lesion but should be considered when a patient presents with a painless axillary or perianal/inguinal mass. There are some histologic features that help in making the diagnosis. There is correlation between degree of differentiation and survival, despite the low number of tumors seen to date. Currently, surgical excision is the treatment of choice. ★★★

P.O. Box 339 (39631)

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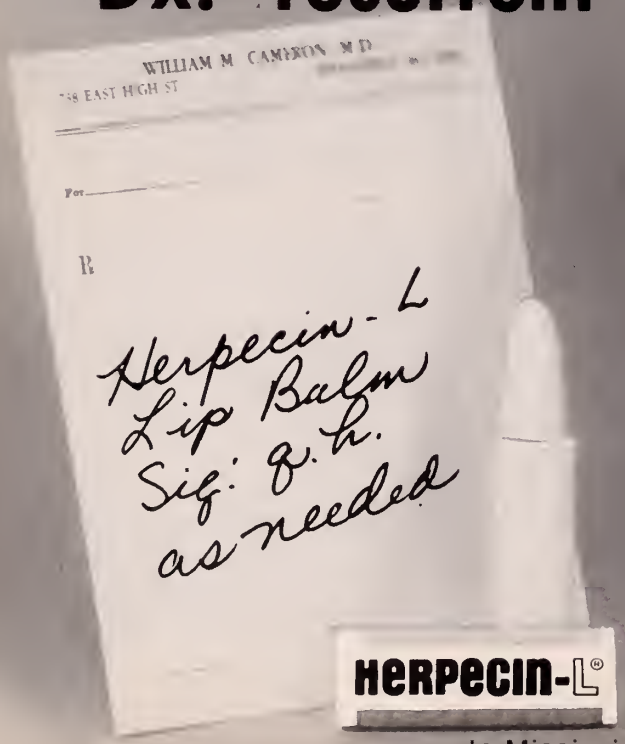
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The President Speaking

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W. JOSEPH H. BURNETT, M.D.
Oxford, Mississippi

We have this year many direct reminders of the need for physicians and their families to re-commit themselves to many areas of community service. Our country, our state, and our communities have been very good to us. Most of us have lifestyles the great majority of Americans can only dream about! Having been well rewarded we must return a portion of our time, talent, and treasury to our communities.

Whether it be "crack," alcohol problems, or teenage pregnancies (which account for 21% of *all* births in Mississippi), many of our problems arise from a breakdown in that most important and irreplaceable institution — the *Family*. It is here we have a unique opportunity. We must enhance family values, which we can do by instruction but can do best by *example*.

Our doctors and their families are expected to be moral and community leaders as well as health care providers. We are leaders in health care, but if we abdicate our role someone else will lead. As citizens we have a right to express our opinions, but to lead we must become publicly involved in our communities. As physicians we seek to heal the sick, but to lead we must be prepared to take action when poor quality care exists. It is easy to hear families calling for help in our communities and our state, but to lead we must teach and exemplify the strong moral values and traditions we all cherish.

Our communities expect our leadership; they deserve our compassion; and more than ever, they need our help and our example. Mississippians are calling for your help in our communities and I hope with God's help we will answer the call.

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
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VOLUME XXVII, NUMBER 11
NOVEMBER 1986

High Finance

Recently, at my son's insistence, I acquired the services of a financial management consultant. After my 30 years of medical practice it was evident to my son (and had been to everyone else for sometime) that I was never going to be a millionaire. To keep peace in the family, I went along with this. I went through pages and pages of "none of their *#!¢#* business" type questions and answered them all to the best of my ability.

The one thing that seemed to stump the experts was "when did I plan to retire?" I didn't want to shake them up, but everyone in these parts knows from experience with the last two physicians who were here that we *all* retire at 85 years and die at 87 years . . . and I don't plan to change that if I can help it. Finally they said that in order for them to help me, I was going to have to decide on a more reasonable retirement age like 65 years . . . I really liked 85 better!

To make a long story short, I did need some more life insurance . . . which I had already planned on getting. "And was I interested in investing in a tax sheltered apartment complex in Seattle?" At that point I asked him if he had been hearing things lately; having headaches and/or dizziness; and whether he had noted a change in his sex life. Anyway we finally decided on investment in mutual funds. Stupid me! I only recently had drawn out the money that I had put in mutual funds for many years and had come out with only a few dollars more than I had put in . . . some people never learn. I thought it was really bad when I got the first notice showing that I had dropped several thousand in loading fees right off the bat, but the full realization comes weekly now when I check my big investment. Have you noticed lately how mutual funds have gone . . . down . . . down . . . down. Oh well, it could have been in a Bangladesh oil field tax shelter. By the way, does someone know of a bridge somewhere that I might buy part interest in?

Somehow my Midas touch has become galvanized. You all please think about me on your way to all those millions of dollars everyone knows you doctors make.

Thank God I am a physician.

JOSEPH E. JOHNSTON, M.D.
Associate Editor

LETTERS

SIRS:

Thank you for giving me the opportunity to comment on our role as the regulatory agency of Home Health Agencies and the medical professions' concerns in this regard.

Home Health Agencies in Mississippi are regulated by a state licensing program and by federal Medicare/Medicaid certification programs. Standards have been developed by the licensing agency with advice from Home Health Agency personnel, physicians, other state agencies, and consumer groups. The purpose of these regulations is to protect the public from unscrupulous operators and unsafe patient care practices. The standards require minimum staffing of agencies (number and appropriate credentialing), appropriate organization, training of personnel, record keeping, patient care planning, coordination of treatments, etc. A further safety net is supplied by audits of records and activities by third party payors. The final and most important safety net is that all visits, treatment and services are initiated and directed by a physician. All referrals must have a doctor's order before care can begin. The Plan of Care that the agency develops must be approved by the physician.

Home Health Agencies developed at a rapid pace in response to the needs of the elderly and the attractive payment system developed by Medicare. Medicare reimbursement is based on cost and the

government has encouraged home health services, thinking that it would reduce overall costs to the Medicare program. Studies have shown that home health services have not become a substitute for inpatient hospital and nursing home services but merely an add-on to the traditional delivery system. Currently we have *138* licensed Home Health Agencies in Mississippi — 82 of these are county health departments, *18* are hospital based agencies and *38* are private agencies. Every county in Mississippi is served by at least three agencies. Based on the numbers above, the Mississippi Legislature imposed a moratorium on the establishment of new agencies in 1983.

Agencies vary in the services that they render. However, all agencies must provide skilled nursing services and one other recognized health service. Most often this is nurse aide service. Physical therapy, occupational therapy, social work service, speech therapy, nutritional services, respiratory services and appliance and equipment services are recognized services.

Because of the prospective payment reimbursement system in hospitals, patients are discharged earlier and sicker than before the system was implemented. Home Health Agencies are seeing patients that are more critical and whose needs are greater.

Quality assurance is built into the system by federal regulations which require self study and the recent innovation of home visits by survey staff. Some third party payers are also home visiting to assure themselves about the quality and the need of care. Patients on the whole are seen fewer times than in the past for a given diagnosis. Patients who do not have adequate support systems or who cannot be taught proper care are being discharged. The important thing to remember is the physician has the last word. He/she monitors the care of the patient and hence each agency to whom patients are referred.

The Division of Licensing and Certification is the licensing and certification agency. Annual surveys are conducted on each of the HHAs on an annual basis. The agency also investigates complaints received regarding home health care.

MENDAL G. KEMP, Director
Division of Health Facilities Licensure
and Certification
P.O. Box 1700
Jackson, MS 39215-1700

Review A Book

The following books have been received. Members of MSMA interested in reviewing any of these volumes should address their requests to Editor, JOURNAL MSMA, P.O. Box 5229, Jackson, MS 39216. After submitting to the JOURNAL a review for publication, you may keep the books for your personal libraries.

The World of Surgery, 1945-1985: Memoirs of One Participant.
James D. Hardy, M.D. Philadelphia: University of Pennsylvania Press, 1986. $34.95.

We Are Not Alone: Learning to Live with Chronic Illness.
Sefra K. Pitzele. Minneapolis: Thompson and Company, 1985. $14.95.

Mammography: A User's Guide. Bethesda: National Council on Radiation Protection and Measurements, 1986.

Medico-Legal Brief

MD Liable For Failing To Get Parental Consent for Abortion on Minor

A physician was liable for battery for not obtaining the consent of a minor's parents before performing an abortion on her, a Louisiana appellate court ruled.

The 16-year-old patient discovered in early October 1982, that she was pregnant. She returned to the physician's office to prepare for the pregnancy termination procedure. She furnished the physician with a document purporting to be her mother's written authorization for the abortion. The next day she returned and the pregnancy was terminated.

A few weeks later, her mother found some documents and prescriptions furnished by the physician to her daughter. When presented with the evidence, the patient admitted having had an abortion.

In an action against the physician, the parents claimed that he committed a battery and deprived them of the joys of grandparenthood. A trial court dismissed all claims.

On appeal, the appellate court said that the note

(Continued on page 308)

Nominees Sought for MSMA Community Service Award

Component societies have until January 3, 1987 to submit nominations for the annual MSMA Community Service Award, which will be presented at the 119th Annual Session next June.

The award recognizes a physician who renders outstanding service to his or her community. The recipient, selected from component society nominees from across the state, is chosen by a committee composed of the MSMA president, president-elect, and three vice presidents.

The award consists of a handsome mahogany plaque which features a cast bronze medallion. The medallion's design symbolizes the close relationship between medicine and the community. The award also carries a $500 contribution by the association to a civic organization designated by the award recipient.

UMC Scientists Seek Patent For Cyanide Poisoning Antidote

University of Mississippi Medical Center scientists have a patent pending with the U.S. Patent Office for an antidote to cyanide poisoning.

Dr. Arthur Hume, professor of pharmacology and toxicology, shares patent rights with the Medical Center and with co-investigators Dr. I. K. Ho, pharmacology department chairman; Dr. J. C. Norris, postdoctoral fellow; and graduate student, Steve Moore.

The antidote is alpha-ketoglutaric acid — a naturally occurring chemical product associated with amino acids in humans and animals.

Currently, its only medicinal use is by physicians who prescribe it to their patients with amino acid deficiencies.

Hume and his colleagues have tested the substance in laboratory rats and mice both as a preventive measure and as an antidote given after exposure to cyanide. Given alone, it was twice as effective at reducing fatalities than the two most commonly used antidotes, sodium thiosulfate and sodium nitrate.

When it was given with sodium thiosulfate, it was 15 times more effective than any known treatment for cyanide poisoning.

A safe effective cyanide antidote would be a boon to firefighters and fire victims alike (who may be exposed to cyanide gas as it is released from burning materials which contain plastic) or to military personnel who may be victims of chemical warfare.

"The current antidotes are either too slow or they have toxic effects of their own," Hume said.

Some 65 percent of all deaths from fire are the result of inhalation of carbon monoxide and cyanide. Current treatments for cyanide exposure actually enhance the potency of the carbon monoxide which may be present, Hume said.

"Cyanide is released into the environment when plastics burn," Hume said. "And with plastic materials so prevalent, cyanide poisoning becomes common, too," he said.

Hume said that alpha-ketroglutaric acid works by binding huge quantities of cyanide. "What that means is that it takes the cyanide much longer to poison the tissues if it's joined to the alpha-ketoglutaric acid molecule."

Given alone, sodium thiosulfate is often too slow to be effective. It converts cyanide to thiocyanate which the body eliminates easily. Alpha ketoglutaric acid gives sodium thiosulfate time to do its work, Hume said.

The next step in Hume's research will be to determine how long the new antidote will last, and if it is effective taken orally.

UMC Announces Faculty Appointments

Three have been named in faculty appointments and promotions in the School of Nursing, the School of Dentistry and centerwide at the University of Mississippi Medical Center.

Dr. Norman C. Nelson, UMC vice chancellor for health affairs, made the announcement following approval by the Board of Trustees of State Institutions of Higher Learning.

New appointments included Maureen G. Propst,

assistant professor of nursing, and Dr. Mona R. Trempe, instructor in biochemistry.

In the School of Dentistry, Dr. Charles O. Parkel, Jr., who is associate professor of periodontics, was named vice chairman of the department.

Ms. Propst attended Mississippi Gulf Coast Junior College and the University of Mississippi in Oxford and earned the B.S. in nursing in 1975 at the University of Mississippi Medical Center, where in 1978, she received the M.S.N. She has been on the nursing staff of University Hospital at the Medical Center since 1973, and was a member of the School of Medicine faculty as instructor in perinatal education in obstetrics and gynecology from 1978-1982. During this time, she also held positions as perinatal educator, inservice educator and research coordinator. Ms. Propst was an instructor in nursing at the Hinds Junior College District Nursing Allied Health Center before joining the UMC nursing school faculty. She is a field nurse with Tokos Medical Corporation and a volunteer cardiopulmonary resuscitation instructor with the American Heart Association.

Dr. Trempe, a 1976 graduate of the University of Vermont, earned the Ph.D. in 1982 at the University of California at Los Angeles and did her postdoctoral research fellowship at the Molecular Biology Institute at UCLA. She has been a research assistant in biochemistry at the University of Vermont School of Medicine, and was a staff research associate at UCLA School of Medicine from 1976-1979. She has been a senior research associate in biochemistry at UMC since 1984.

Dr. Parkel joined the UMC faculty in 1980 as associate professor of periodontics. He earned the B.S. in 1953, the D.M.D. in 1956, the M.S. in clinical dentistry in 1962, and the certificate of training in periodontics in 1964, all at the University of Alabama. In the U.S. Air Force Dental Corps from 1956-1980, Dr. Parkel is a two-time recipient of the Air Force Commendation Medal and holds the meritorious service medal and the legion of merit. He was Fifth Air Force consultant in periodontics for Japan and Korea from 1970-1972; military regional consultant in periodontics to the Surgeon General's Office at the Scott USAF Medical Center 1972-1977; and assistant professor of clinical periodontics at Washington University School of Dental Medicine 1972-1976. He also has been a visiting faculty member at Lakeland College School of Dental Hygiene and senior medical service consultant for the USAF Dental Service.

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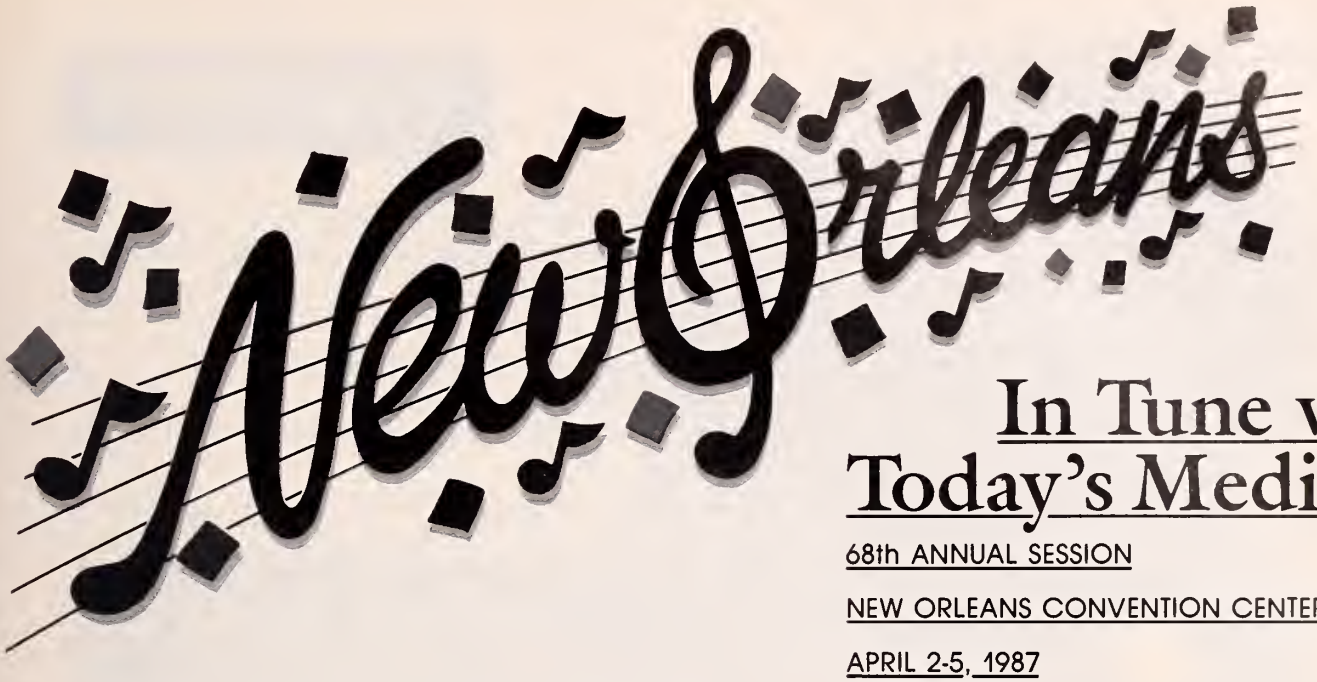
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MD601

Medico-Legal Brief

(Continued from page 304)

of consent furnished by the patient to the physician was written and signed by her cousin. A Louisiana statute required that the parent or guardian of a minor consent in a notarized statement to the abortion. The statement furnished by the patient to the physician was not notarized. Since the physician testified that almost all of his practice was abortions, he was aware of the legal requirement for consent for a minor seeking an abortion. The court awarded the patient $400 for the cost of the operation and $3,000 for pain and suffering.

The court rejected the claims by her parents for denial of their right to grandparenthood. The court said there was no law to support that recovery. — *Cage v. Wood,* 484 So.2d 850 (La.Ct. of App., Feb. 25, 1986)

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EIGHTH ANNUAL MISSISSIPPI PERINATAL POSTGRADUATE COURSE
Ramada Renaissance Hotel, Jackson

Dec. 13-14
OTOLARYNGOLOGY, ORTHODONTICS AND SLEEP DISORDERS: THE RELATIONASHIP OF HEAD/NECK AND ORAL DEVELOPMENT TO SLEEP APNEA, BRUXISM AND RELATED SLEEP DISORDERS
Gulf Park Conference Center, Long Beach

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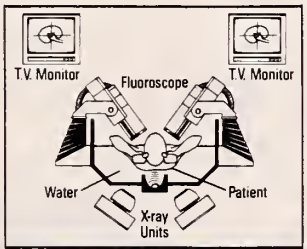


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PERSONALS

ROBERT F. ALLEN has associated with Rush Medical Group, P.A. of Meridian for the practice of neurology, electromyography, and electroencephalography.

W. O. BARNETT of Jackson recently addressed the New England Ostomy Association in Hartford, Connecticut.

BLAIR BATSON of UMC attended a recent meeting of the American Board of Pediatrics in Memphis.

DAVID W. BOMBOY of Hattiesburg has enrolled in the Guardian Society of the University of Mississippi Alumni Association.

ROBERT BUCKLEY and DAVID EAKES of Columbus announce the association of LANCE WYBLE for the practice of pediatrics.

TOMMY J. CAMPBELL has associated with McGee-Taylor-Burke clinic of Clarksdale for the practice of internal medicine.

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RICHARD CONN of Hattiesburg has been elected to a 12-member study panel of national experts in hip joint replacement surgery.

MARTIN DALTON of UMC lectured to the medical staff at the Orlando Regional Medical Center in Orlando, Florida.

ILEY DILLION of Natchez has been installed as chief of staff at Jefferson Davis Memorial Hospital. JOHN YOUNG was elected vice chief, MARGARET VELLER was re-elected secretary.

CLAY EASTERLY of Biloxi announces his retirement from the practice of general surgery and thoracic surgery.

OWEN EVANS of UMC presented pediatric grand rounds at the University of Missouri School of Medicine in Columbia.

JEAN GUYTON GISPEN has associated with Internal Medicine Associates of Oxford for the practice of internal medicine and rheumatology.

THOMAS E. GOYER of Iuka was invited to take part in a nationwide teleconference on nutritional problems for seriously ill surgical patients.

DELORES ELAINE HATCHER has joined the staff of Vicksburg Clinic for the practice of medicine.

WOOD HIATT of UMC presented a lecture to the combined staffs of Riverside Hospital and St. Dominic-Jackson Memorial Hospital recently.

TOM MITCHELL of Vicksburg has been named to the board of trustees of the Mercy Regional Medical Center.

TOXEY MORRIS of Hattiesburg has completed requirements for certification in extracorporeal shock wave lithotripsy.

JOHN MORRISON of UMC presented grand rounds at Albert Einstein University in New York and Emory University in Atlanta.

SESHADRI RAJU of UMC attended the Southeastern Organ Procurement Foundation board of directors meeting in Atlanta.

NATHAN SHAPPLEY of Hattiesburg has enrolled in the Guardian Society of the University of Mississippi Alumni Association.

CURTIS W. SLIPMAN announces the opening of his practice of physical medicine and rehabilitation at Mississippi Methodist Hospital and Rehabilitation Center in Jackson.

(Continued)

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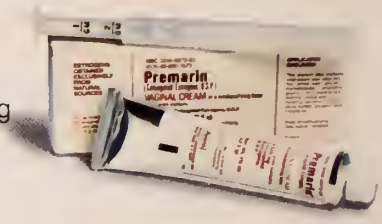
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BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)*

PREMARIN® Brand of conjugated estrogens tablets, USP
PREMARIN® Brand of conjugated estrogens Vaginal Cream in a nonliquefying base

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA

Three independent case control studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case control studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semiannual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equiestrogenic doses.

2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY

The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a non-steroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb reduction defects. One case control study estimated a 4.7-fold increased risk of limb reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe *vasomotor* symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) **Osteoporosis (abnormally low bone mass).** Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae. PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important, product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (See Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. There are now reports that estrogens increase the risk of carcinoma of the endometrium in humans. (See Boxed Warning.) At the present time there is no satisfactory evidence that estrogens given to postmenopausal women increase the risk of cancer of the breast, although a recent study has raised this possibility. There is a need for caution in prescribing estrogens for women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement, it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nontatal myocardial infarction, pulmonary embolism and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Preexisting uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

a. Increased sulfobromophthalein retention.

b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.

c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG; free T4 concentration is unaltered.

d. Impaired glucose tolerance.

e. Decreased pregnanediol excretion.

f. Reduced response to metyrapone test.

g. Reduced serum folate concentration.

h. Increased serum triglyceride and phospholipid concentration. As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea; premenstrual-like syndrome; amenorrhea during and after treatment; increase in size of uterine fibromyomata; vaginal candidiasis; change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness; mental depression; chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria; edema; changes in libido.

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females.

DOSAGE AND ADMINISTRATION:

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1. *Given cyclically for short-term use only.* For treatment of moderate to severe *vasomotor* symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. *Given cyclically.* Female castration. Osteoporosis. Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Osteoporosis—0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off).

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only. For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three-to-six month intervals.

Usual dosage range: 2 to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

References:

1. Whitehead MI, Townsend PT, Pryse-Davies J, et al: Effects of estrogens and progestins on the biochemistry and morphology of the postmenopausal endometrium. *N Engl J Med* 1981;305:1599-1605. **2.** Paterson MEL, Wade-Evans T, Sturdee DW, et al: Endometrial disease after treatment with oestrogens and progestogens in the climacteric. *Br Med J* 1980;280:822-824. **3.** Magos AL, Brincat M, Studd JWW, et al: Amenorrhea and endometrial atrophy with continuous oral estrogen and progestogen therapy in postmenopausal women. *Obstet Gynecol* 1985;67:496-499. **4.** Whitehead MI, Lane G, Siddle N, et al: Avoidance of endometrial hyperstimulation in estrogen-treated postmenopausal women. *Semin Reprod Endocrinol* 1983;1:1;41-52. **5.** Barnes RB, Roy S, Lobo RA: Comparison of lipid and androgen levels after conjugated estrogen or depo-medroxyprogesterone acetate treatment in postmenopausal women. *Obstet Gynecol* 1985;66:216-219.

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PERSONALS/Continued

JOHN STRIPLING of Gulfport presented a program on sexual problems in diabetic men at Southwest Mississippi Regional Medical Center in McComb.

ED THOMPSON of Jackson presented a lecture on AIDS at Belhaven College in Jackson.

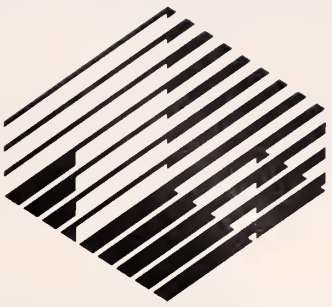
PLEZ TINSLEY of Meridian was visiting professor at the Dallas Ear Foundation meeting at Baylor University Hospital in Dallas.

WILLIAM C. TOUCHSTONE of Belzoni announces the association of JAMES R. COBB for the practice of family medicine.

LAMAR WEEMS of UMC lectured during the Lee County Leadership Conference in Tupelo recently.

C. E. WIGGINS of Pascagoula spoke on osteoporosis at a community health education seminar recently.

J. K. WILLIAMS of Pascagoula spoke on eye diseases during a recent community health education seminar.



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GENERAL INTERNIST to join Internal Medicine Clinic in Laurel, MS. Charles D. Cannon, Jr., M.D., Internist, P.O. Box 2756, Laurel, MS 39440; (601) 649-2863.

ONCOLOGIST to join Internal Medicine Clinic in Laurel, MS. John M. Wallace, M.D., P.O. Box 2756, Laurel, MS 39440; (601) 649-2863.

EMERGENCY ROOM physician needed to staff recently expanded emergency room coverage. Salary negotiable. Small town. 44-bed hospital approved for federal programs, located in central Mississippi. Contact Paul W. Strode, Box 428, Forest, MS 39074.

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PHYSICIANS NEEDED

Physicians (especially specialists such as ophthalmologists, pediatricians, orthopedists, neurologists, etc.) interested in performing consultative evaluations (according to Social Security guidelines) should contact the Medical Relations Office. WATS 1-800-962-2230; Jackson, 922-6811; extensions 2275, 2276, 2249 or 2190.

The Mississippi Disability Determination Services now has a program available for medical society meetings and hospital staff meetings. The purpose of this program is to explain the Social Security Disability program, the medical documentation requirements, and how the disability determination process works. Any group interested in this presentation should also contact the Medical Relations Office.

ALLERGIST position available. Board certified or board eligible allergist needed by largest multi-specialty group practice in state. Located 75 miles north of Mississippi Gulf Coast. Contact T. G. Thornton, Administrator, Hattiesburg Clinic, 415 South 28th Ave., Hattiesburg, MS 39401; (601) 268-5601.

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PSYCHIATRIST needed. Mississippi Department of Corrections is currently seeking applications for a fully licensed board certified Psychiatrist at the Parchman Penitentiary Medical/Dental Facility. The incumbent will directly supervise in and out patient services at the State Penitentiary. The hospital facility is approaching full accreditation with a 60 bed capacity, 14 of which are located in the Psychiatric ward. The pathology is diverse and interesting with present emphasis on a sex offender program. Located in Sunflower County, the Parchman facility now houses in excess of 4,200 inmates. Salary: $65,000 or negotiable for higher, depending upon experience, qualifications, etc. The State also offers family housing at a nominal rate, eleven paid holidays per year, liberal major medical and personal leave policies, and a well rounded insurance program. Interested persons may inquire by contacting Mr. William Steiger, Hospital Administrator, P. O. Box E, Parchman, MS 38738 or call (601) 745-6611, ext. 631.

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Index to Advertisers

American College of Physicians 307
Ayerst Laboratories
..... 298A, 298B, 298C, 298D, 310B, 310C, 310D

Bryant Galleries 310

Campbell Laboratories 300

Forrest General Hospital 309

Harreld Chevrolet-Oldsmobile 308
F. E. Hebert Hospital 298

Eli Lilly and Company **10B**

Medical Assurance Co. of Miss. **6**
MSMA Benefit Plan and Trust **10**

Premier Printing 308

Roche Laboratories ..... **third, fourth covers**

Smith Kline and French 310B
Sterolizer **9**
St. Dominic/Jackson Memorial Hospital ..... **second cover**

The Upjohn Company **10A**
Trustmark 311

U. S. Army 297

Jon Wimbish 294
James Wooldridge Co. 306

Thomas Yates & Co. **12**



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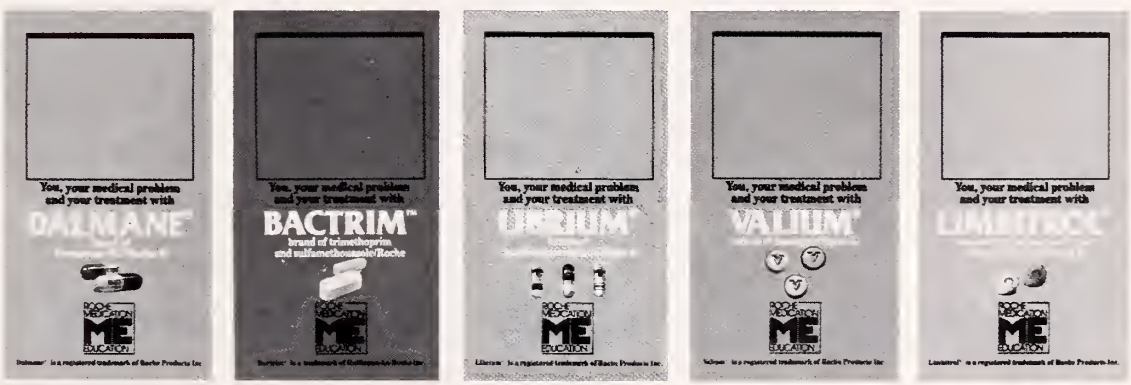
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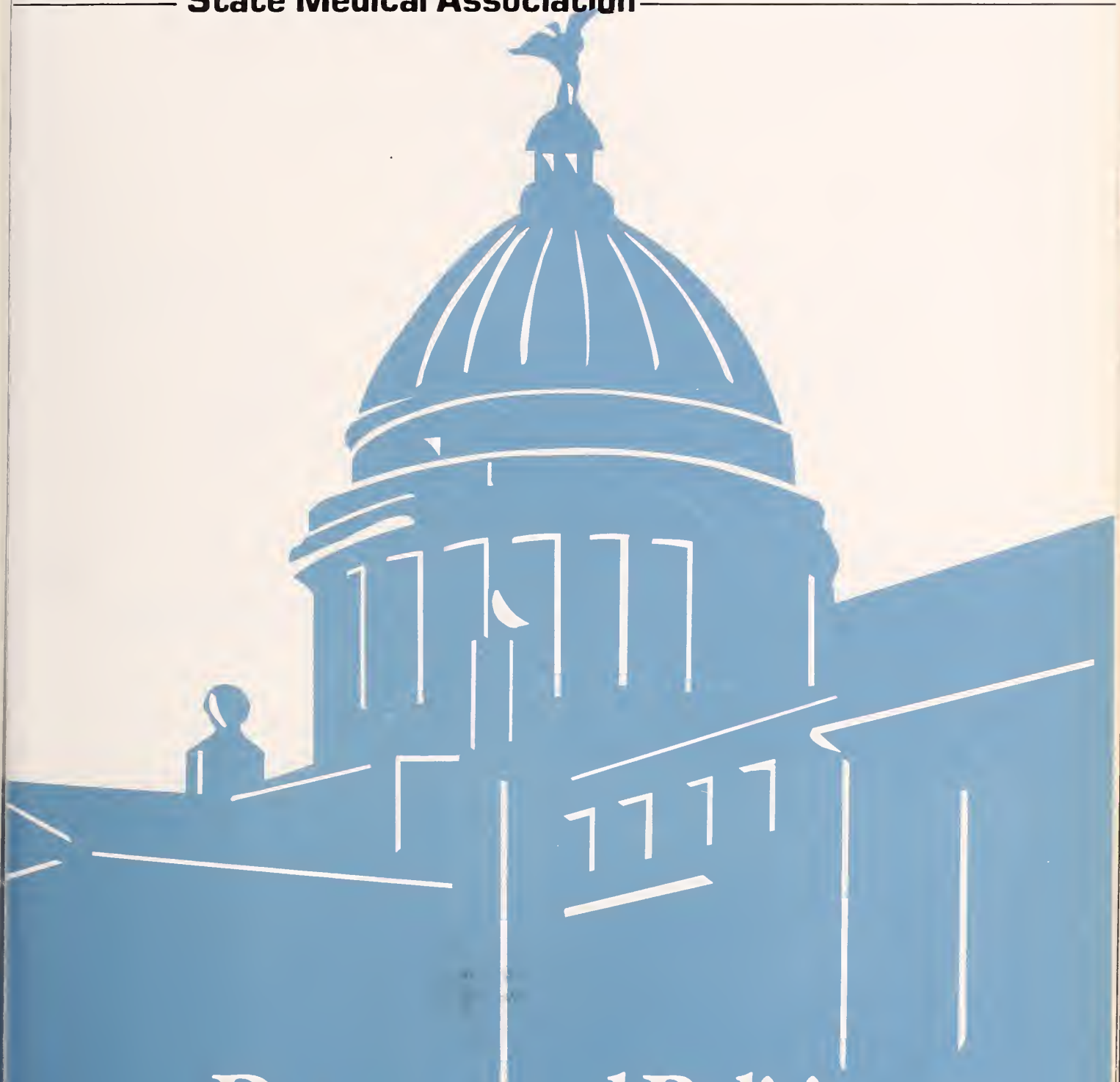
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December 1986

JOURNAL of the MISSISSIPPI State Medical Association



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CONTENTS

ORIGINAL PAPERS

Mohs Surgery in the Treatment of Skin Cancer — **313** John M. Abide, M.D.

Management of Hypertension in Early Pregnancy — **317** G. Rodney Meeks, M.D. and Michel E. Rivlin, M.D.

EDITORIAL

A Classic Case of Over-Utilization — **323** Arthur A. Derrick, M.D.

THIS MONTH

Doctors and Politics
322 The President Speaking
323 Medico-Legal Brief
324 Medical Organization
328 New Members
330 Personals
333 Index

"Doctor's and Politics: Looking Ahead to 1987" is the topic of Dr. Burnett's president's page this month (page 322). Cover design by Bill Tyler of Jackson.

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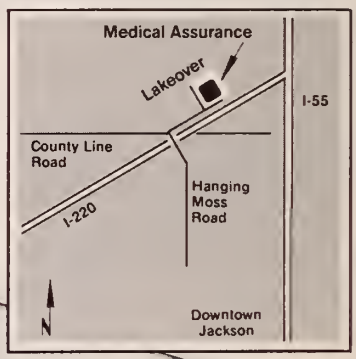
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NEWSLETTER

December 1986

Dear Doctor:

Nearly 75 percent of American adults favor withdrawing life support from hopelessly ill patients under certain conditions, overwhelming majorities favor three alternatives to financing health care for the elderly, and two-thirds believe the government should pay for health care for the homeless. Those were findings of an AMA national survey reported in the November 28 issue of American Medical News.

> Sixty percent of the public believes payments for medical care for the elderly under the Medicare program should be based on the patient's income. Reflecting current Medicare policy, 35 percent of the respondents believe Medicare patients should be reimbursed for their health care "regardless of how rich or poor they are."
>
> Almost eight out of ten would be willing to make tax-deductible contributions to individual health retirement accounts to supplement the medical benefits available through Medicare. Twenty-three percent of those surveyed said they would not make such contributions. The concept of "Health IRAs" was endorsed by the AMA House of Delegates at its 1986 annual meeting as part of a comprehensive proposal to ensure adequate financing of health care for the elderly.

Although it is still several months away, it's not too soon to be making plans to attend MSMA's 119th Annual Session, June 3-7, 1987, in Biloxi. The meeting will be held at the Royal d'Iberville Hotel. Committees are at work completing plans for the scientific meetings, specialty society and alumni functions, and many special events. Plan to be there, and bring your family, too.

From the staff of MSMA: Best Wishes for a Happy Holiday Season! May you have the richest blessings of Christmas and a wonderful new year.

Sincerely,

Patsy Silver

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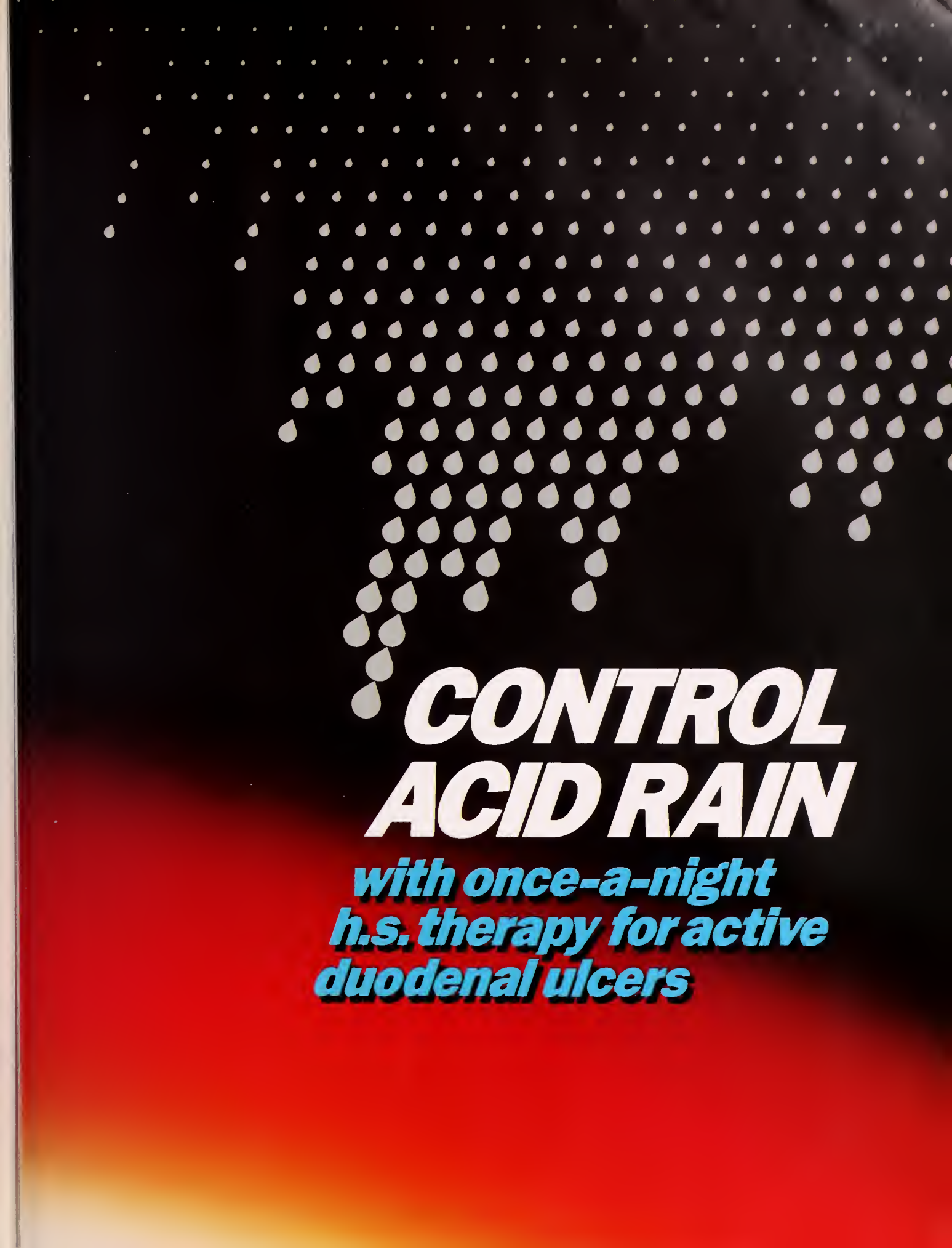
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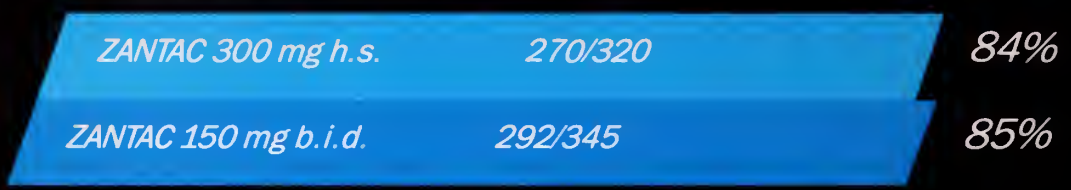
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CONTRAINDICATIONS: ZANTAC® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS: General: 1. Symptomatic response to ZANTAC® therapy does not preclude the presence of gastric malignancy. 2. Since ZANTAC is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function. Caution should be observed in patients with hepatic dysfunction since ZANTAC is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during ZANTAC therapy, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions: Although ZANTAC has been reported to bind weakly to cytochrome P-450 in vitro, recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions which suggest that ZANTAC may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no indication of tumorigenic or carcinogenic effects in lifespan studies in mice and rats at doses up to 2,000 mg/kg/day.

Ranitidine was not mutagenic in standard bacterial tests (*Salmonella, E coli*) for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next nine weeks.

Pregnancy: ***Teratogenic Effects: Pregnancy Category B:*** Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ZANTAC. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: ZANTAC is secreted in human milk. Caution should be exercised when ZANTAC is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Use in Elderly Patients: Ulcer healing rates in elderly patients (65 to 82 years of age) were no different from those in younger age groups. The incidence rates for adverse events and laboratory abnormalities were also not different from those seen in other age groups.

ADVERSE REACTIONS: The following have been reported as events in clinical trials or in the routine management of patients treated with oral ZANTAC®. The relationship to ZANTAC therapy has been unclear in many cases. Headache, sometimes severe, seems to be related to ZANTAC administration.

Central Nervous System: Rarely, malaise, dizziness, somnolence, insomnia, and vertigo. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients.

Cardiovascular: Rare reports of tachycardia, bradycardia, and premature ventricular beats.

Gastrointestinal: Constipation, diarrhea, nausea/vomiting, and abdominal discomfort/pain.

Hepatic: In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid IV for seven days, and in 4 of 24 subjects receiving 50 mg qid IV for five days. With oral administration there have been occasional reports of reversible hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice.

Musculoskeletal: Rare reports of arthralgias.

Hematologic: Rare reports of reversible leukopenia, granulocytopenia, thrombocytopenia, and pancytopenia.

Endocrine: Controlled studies in animals and man have shown no stimulation of any pituitary hormone by ZANTAC and no antiandrogenic activity, and cimetidine-induced gynecomastia and impotence in hypersecretory patients have resolved when ZANTAC has been substituted. However, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving ZANTAC, but the incidence did not differ from that in the general population.

Integumental: Rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia.

Other: Rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia) and small increases in serum creatinine.

DOSAGE AND ADMINISTRATION: Active Duodenal Ulcer: The current recommended adult oral dosage is 150 mg twice daily. An alternate dosage of 300 mg once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

Maintenance Therapy: The current recommended adult oral dosage is 150 mg at bedtime.

Pathological Hypersecretory Conditions (such as Zollinger-Ellison Syndrome): The current recommended adult oral dosage is 150 mg twice a day. In some patients it may be necessary to administer ZANTAC® 150-mg doses more frequently. Doses should be adjusted to individual patient needs, and should continue as long as clinically indicated. Doses up to 6 g/day have been employed in patients with severe disease.

Benign Gastric Ulcer: The current recommended adult oral dosage is 150 mg twice a day.

GERD: The current recommended adult oral dosage is 150 mg twice a day.

See full prescribing information for dosage adjustment for patients with impaired renal function.

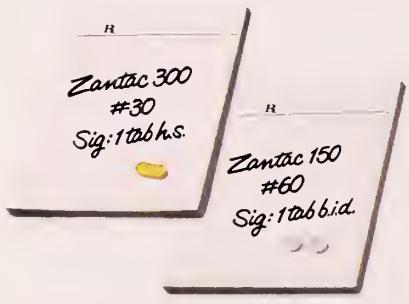
HOW SUPPLIED: ZANTAC® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) and unit dose packs of 100 tablets (NDC 0173-0393-47).

ZANTAC® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 tablets (NDC 0173-0344-42) and unit dose packs of 100 tablets (NDC 0173-0344-47).

Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.

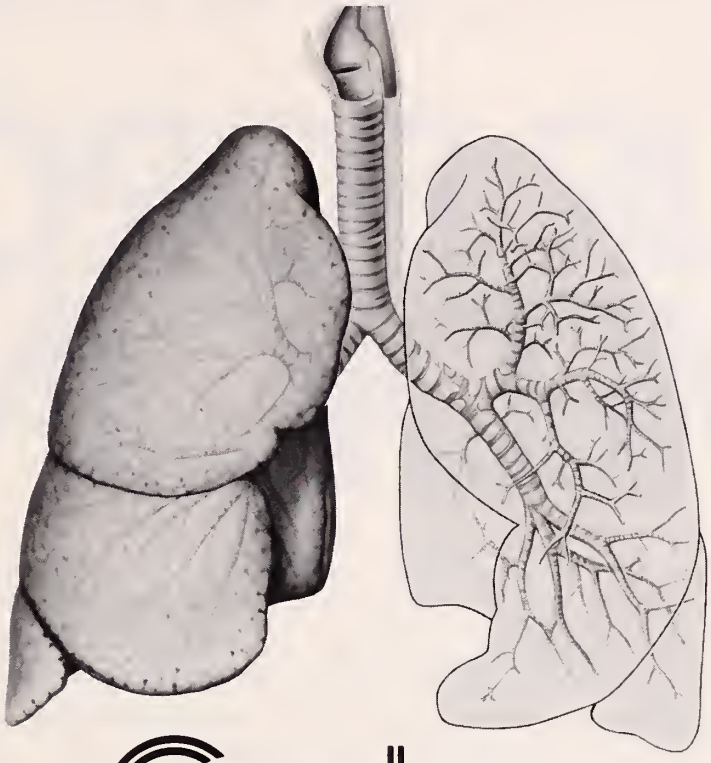
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Haemophilus influenzae, H influenzae, Streptococcus pneumoniae, Streptococcus pyogenes
(ampicillin-susceptible) (ampicillin-resistant)

Note: Ceclor® is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Ceclor® (cefaclor)

Summary. Consult the package literature for prescribing information.

Indications: Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae, Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci).

Contraindications: Known allergy to cephalosporins.

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- In renal impairment, safe dosage of Ceclor may be lower than that usually recommended. Ceclor should be administered with caution in such patients.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, erythema multiforme, serum-sickness-like reactions): 1.5%; usually subside within a few days after cessation of therapy. These reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children)
- Abnormal urinalysis; elevations in BUN or serum creatinine
- Positive direct Coombs' test
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly)

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DATELINE

Drug Abuse As Death Contributing Factor

Jackson, MS - According to the State Health Department, since 1980 an average of seven deaths per year have been directly attributable to drug abuse or drug dependency. However, the number of cases in which drug abuse or drug dependency (excluding alcohol) is a contributing factor has increased dramatically. The increase is occurring among Mississippians under age 40, and has more than tripled since 1980.

Tri-State Thoracic Case Conference Set

Jackson, MS - The 31st Tri-State Thoracic Case Conference will be held Janaury 9-10, 1987, at the Royal d'Iberville Hotel in Biloxi. Topics to be presented include "Use of Fine Needle Aspirate," "Malignant Presentations," "Chest Disease with Vascular Involvement," "Pulmonary Nodules," and "Pulmonary Problems in the Obstetrical Patient." For information, contact the Mississippi Thoracic Society, P.O. Box 9865, Jackson, MS 39206.

Chemical Dependency Workshop Slated

Jackson, MS - A workshop on "Chemical Dependency in the Health Related and Legal Professions" will be held January 30-31, 1987, at the Holiday Inn North in Jackson. Professional societies from Mississippi and surrounding states will be represented at the workshop, and faculty members include directors of impaired professional programs from Mississippi, Tennessee, Florida, and Virginia. For information call 601-366-7483 or write to Caduceus Club of MS, 440 Bounds Street, Suite A, Jackson, MS 39206.

Organ Donor Protocols To Be Required

Washington, DC - Beginning October 1, 1987, hospitals participating in Medicare will be required to establish written protocols for identification of potential organ donors. Protocols must include: assurance that families of potential donors are made aware of the option of donation; encouragement of discretion and sensitivity with respect to families; and a requirement to notify organ procurement agencies of potential donors.

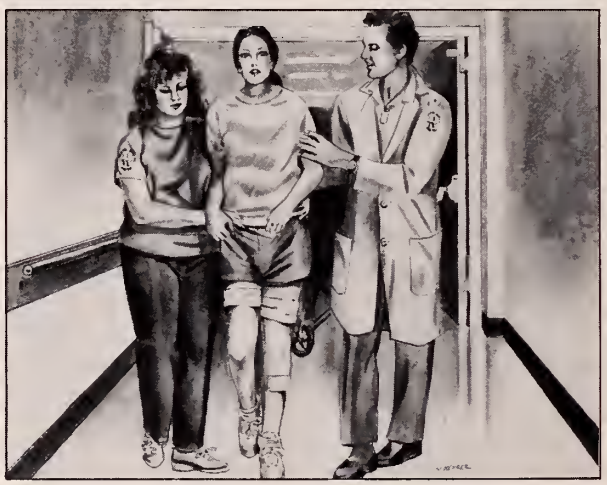
Generic Drugs Not Necessarily Best Buy

Chicago, IL - Buying generic drugs doesn't always guarantee the best price for consumers, says a report in the November 13 JAMA. The study found wide price variation within and among pharmacies and says "an important number of individual consumers" pay more for generics than name brands. This occurs, the study found, even though the generics cost pharmacies less than comparable name brands.

Brain Injury Rehab. 700,000 Reasons.

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J-6138 January 1986

Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: **Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired.** If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

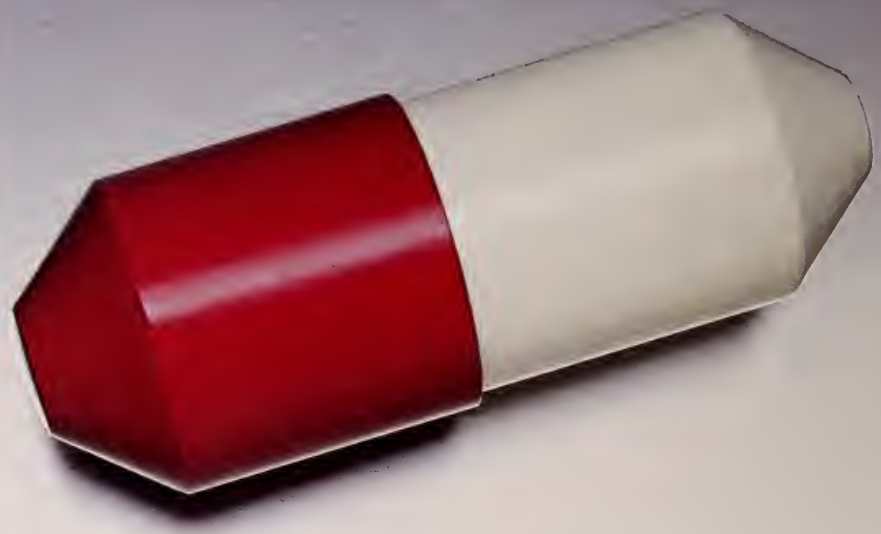
Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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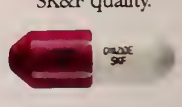
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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
December 1986, XXVII, Number 12

ORIGINAL PAPERS

Mohs Surgery in the Treatment of Skin Cancer

JOHN M. ABIDE, M.D.
Greenville, Mississippi

Skin cancer, especially if recurrent, can often present a difficult therapeutic problem. This is especially true in cosmetically or functionally critical areas. Ultimately, cure is dependent on obtaining margins which are free of residual tumor. The author notes that Mohs surgery is currently the best technique to ensure cancer-free margins.

MOHS SURGERY is a technique for skin cancer removal that utilizes a three dimensional approach to margin control to achieve the highest cure rate of available methods. This is made possible through a unique method of tumor excision and tissue processing that allows microscopic evaluation of both lateral and deep margins simultaneously. The technique was developed by Dr. Frederic Mohs in 1941,[1] and more recent improvements allow the procedure to be performed as outpatient surgery.[2]

Mohs surgery consists of the surgical removal of thin layers of tissue in the bed of the cancerous lesion and the subsequent microscopic examination of this removed tissue at the time of surgery.[3] Further tissue removal is dictated by whether the previously removed tissue is still positive for tumor at the deep or lateral margins. When all margins are found histologically to be free of tumor, the surgery is complete. At that time, the wound can be closed primarily or be allowed to granulate and epithelialize secondarily. The advantage of this technique is its unequaled cure rate, especially for recurrent skin cancer.

Technique

The patient's lesion is anesthetized locally, and the tumor is debulked by curettement[3] (see Figure 1). The tumor bed is then excised, with the scalpel initially angled at 45° to the skin surface. The thin layer of tissue removed includes all points of contact between tumor and patient. Should examination of its undersurface prove free of cancer, it can be assumed that no further tumor remains on the patient, based on the concept of tumor extension by continuity.[1] Microscopic examination of the undersurface of the removed tissue is done by flipping the tissue, dividing it into numbered pieces small enough to mount on a cryostat, and marking the edges with dyes to permit precise orientation of each section when viewed under the microscope. The pieces are then mounted on the cryostat, sections are taken from the exposed undersurface of the tissue, and microscopic slides are made. Any tumor then detected microscopically can be localized to a specific location within the surgical wound because each

Dr. Abide is engaged in the private practice of dermatology in Greenville, MS.

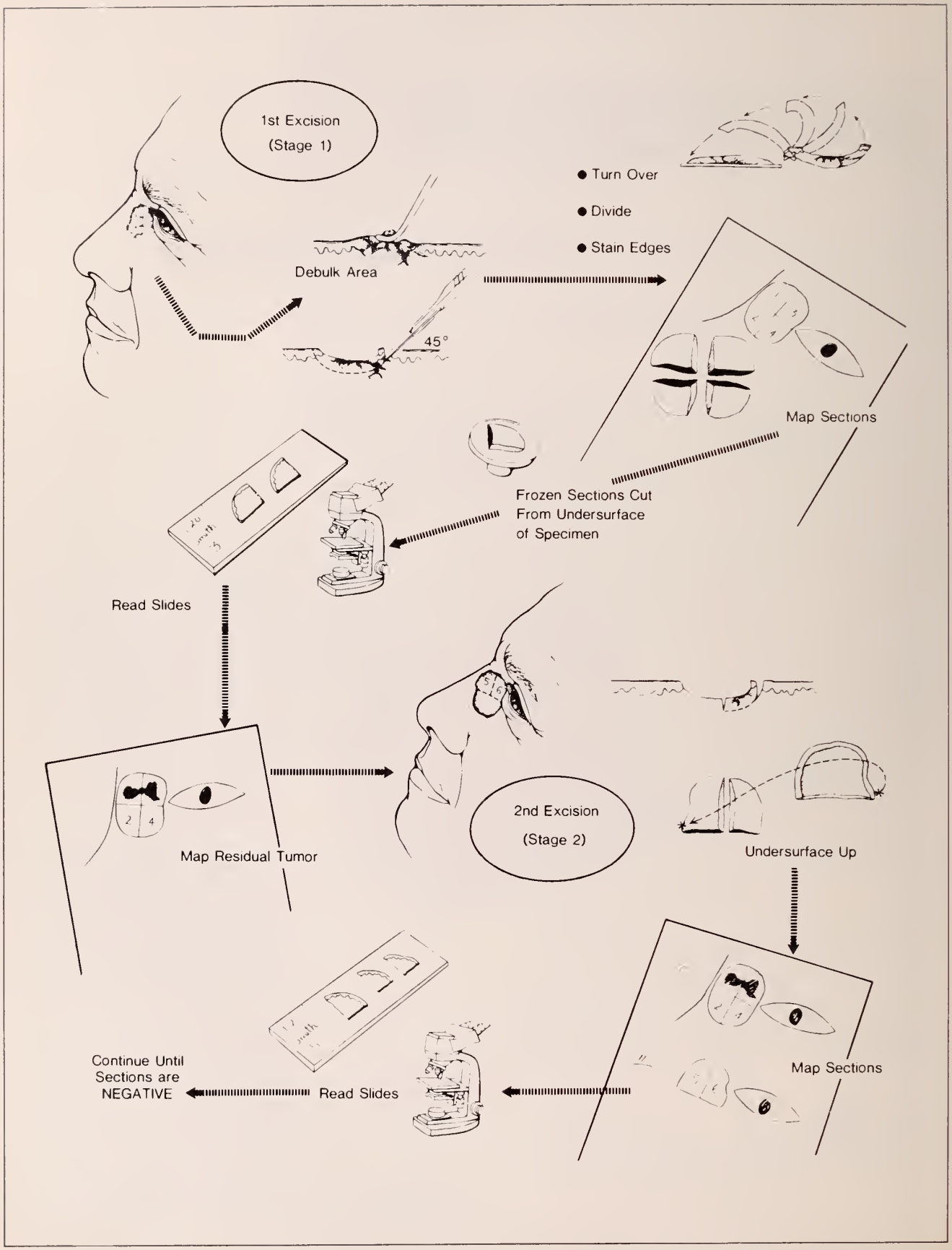


Figure 1. Schematic representation of technique of Mohs surgery. See text for detailed explanation. (Reprinted from Archives of Dermatology, Volume 119, September 1983, page 763, copyright 1983, American Medical Association. Used with permission.)

numbered section corresponds to a specific location as defined by a patient lesional map made at the time of surgery. By further surgery, residual tumor is removed layer by layer in just those locations where it is present. This allows maximum conservation of normal uninvolved tissue and the most thorough removal of any remaining tumor.

Indications

Mohs surgery is the treatment of choice for basal cell and squamous cell carcinomas that are recurrent, incompletely excised, located in high recurrence areas, of large size, or histologically more aggressive.

Primary basal and squamous cell carcinomas have a 95% cure rate when initially treated by surgical excision, electrodessication and curettage, x-ray, or cryosurgery.[4] With primary lesions, Mohs surgery has a cure rate of 98%. However, recurrent skin cancer, when retreated by electrodessication or surgical re-excision, has only a 60% cure rate.[5] This is in contrast to a 95% cure rate for Mohs surgery with recurrent tumors.[6] Recurrent tumors often exhibit a distorted root pattern due to the presence of scar and the full extent of the tumor is not clinically apparent. Even routine margin evaluations as performed by most pathologists do not ensure that margins said to be "free of tumor" are truly free from asymmetric tumor extension present beyond the small random portion of the margin actually examined[7] (see Figure 2). Only the complete examination of all deep and lateral margins as performed in the Mohs technique can detect such occult tumor extensions (see Figure 3).

When a tumor involves the surgical margin, studies show a recurrence rate of 33% if no further surgery is performed.[8] Mohs surgery offers an excellent method to treat residual skin cancer in these cases in which well-defined clinical margins are often lacking.

Certain anatomic areas exhibit a higher recurrence rate than others. These areas include the nasolabial fold, the nasal septum, the periorbital area, especially the canthal regions, and the periauricular areas. These areas coincide with the embryonic fusion junctions of the face, and cancers overlying these seams tend to penetrate downwards with little resistance. Consequently, their deep extension is easily underestimated clinically. With Mohs surgery, microscopic control of margins enables the complete excision of tumor in these locations. This is especially important in that these same areas are cosmetically so conspicuous and the minimal removal of uninvolved tissue is essential to preserve their normal appearance.

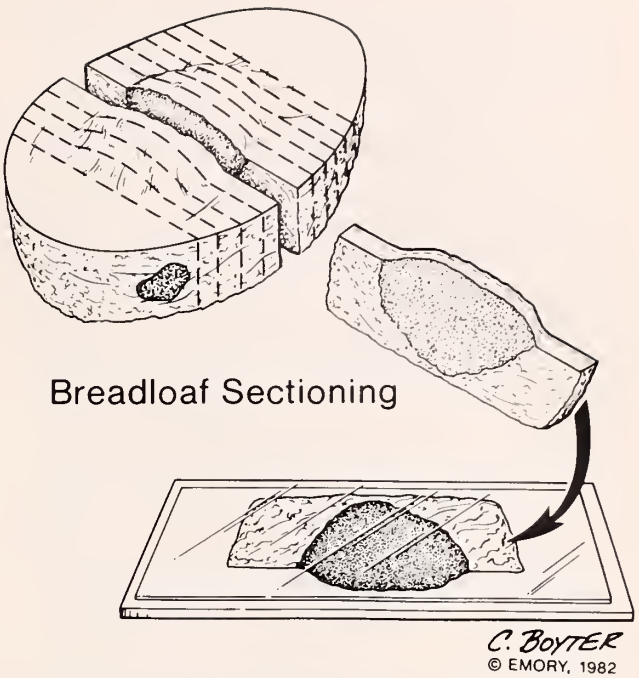


Figure 2. Routine pathological processing does not allow complete examination of margins. Asymmetric tumor extensions may remain undetected.

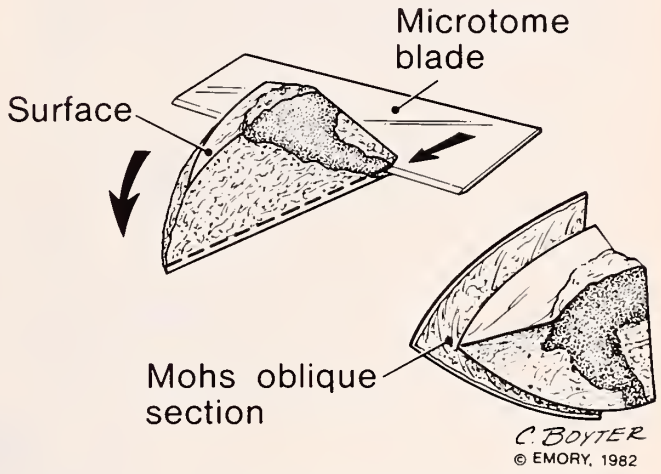


Figure 3. Mohs processing allows complete examination of lateral and deep margins. (Figures 2 and 3 reprinted, with permission, from Plastic and Reconstructive Surgery, Volume 73, Number 3, pages 492-496, March 1984; "The Meaning of Surgical Margins," by J. M. Abide, F. Nahai, and R. G. Bennett.)

Finally, large or histologically more aggressive skin cancers show a proportionately higher recurrence rate. Such tumors tend to have a greater sub-

clinical extension, and accurate tumor-free margins are not easily determined by clinical inspection.[9] Again, Mohs surgery provides the highest cure rate for these cancers.

Post-Surgical Management

The wound defects resulting from Mohs surgery are ideally suited for immediate repair by simple suturing, grafting, or flap coverage. The Mohs surgeon can work in conjunction with the plastic surgeon in cases requiring reconstruction. With especially large or histologically aggressive cancers, tumors that have had previous radiation treatment, or those that have recurred numerous times, it is sometimes wise to allow the wound to heal by granulation and epithelialization in order to allow any further recurrence to become apparent.[10] After one or two years, a complete repair can be performed if indicated, with less concern about recurrence.

Summary

Mohs surgery offers the highest cure rate for primary or recurrent skin cancer, regardless of size, location, histologic aggressiveness, or number of previous recurrences. It can be performed as an outpatient procedure under local anesthetic, and is therefore a cost effective procedure in the management of difficult lesions. ★★★

Acknowledgement

Thanks to Pam Vaculin for assistance in preparation of this article.

1209 South Main Street (38701)

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Obstetrics and Gynecology Grand Rounds:
Clinical Case Management XIII

Management of Hypertension in Early Pregnancy

G. RODNEY MEEKS, M.D., Series Coordinator
MICHEL E. RIVLIN, M.D., Moderator

DR. RIVLIN: A 20-year-old, gravida 1, black female was referred to the Obstetrics Department at the University of Mississippi Medical Center at 17 weeks gestation. Since the onset of the pregnancy she had experienced episodes of severe headache, dizziness, nausea, sweating and vomiting. These occurred with sudden onset twice daily, and lasted about 5 minutes. They were sometimes initiated by emotional changes but also occurred while asleep. During one attack her physicians documented a blood pressure of 200/150 mmHg. She had been hypertensive since 1982 and the hypertension had been difficult to control. At the time of referral she was taking methyldopa (Aldomet) 250 mg qid. There was no family history of hypertension.

Physical examination revealed a blood pressure reading of 100/80 mmHg, a pulse of 100/min. The fundal height was 18 cm and fetal heart tones were present. The patient was clinically euthyroid. No cafe au lait spots or neurofibromata were identified.

What is the significance of hypertension early in pregnancy?

DR. SANDERS: Two to five percent of pregnancies are affected by chronic essential hypertension which is, of course, a disease independent of pregnancy. The history is most helpful. Specifically, hypertension in a previous pregnancy or in a multiparous patient suggests chronic hypertension in the present pregnancy. Evidence of retinopathy and cardiac enlargement are indicative of longstanding hypertension. Patients over age 30 or having a systolic blood pressure over 200 mmHg are more likely to be chronically hypertensive.

From the Department of Obstetrics and Gynecology, University Medical Center, Jackson, MS

Panelists: C. J. Blackburn, M.D., Picayune; C. J. Sanders, M.D., Tupelo; and John G. Shields, M.D., Ackerman.

DR. RIVLIN: What are the unusual causes of hypertension in early pregnancy? What do you do in your routine practice so as not to miss them?

DR. SHIELDS: Hypertension secondary to renal disease is often suggested by the history, such as previous glomerulonephritis, chronic infections or long standing diabetes. Proteinuria in early pregnancy together with abnormality in the SMAC or the creatinine clearance are, of course, supportive factors. Far less common are conditions such as coarctation of the aorta. Episodic events would lead one to perform a catacholamine secretion screen for pheochromocytoma. Furthermore, once in awhile, hypertension in early prenancy may be associated with trophoblastic disease. Abnormalities of thyroid secretion may also be manifested by transient hypertension.

DR. RIVLIN: What tests are necessary in this patient?

DR. BLACKBURN: The history is obviously very classic for a pheochromocytoma. Certainly a valinylmandelic acid (VMA) at the very least should be carried out. If the patient is receiving alphamethyldopa the VMA may be falsely reduced while causing an increase in the catecholamines. All medications should, therefore, be discontinued if possible for at least one week prior to assessment.

DR. RIVLIN: What is your approach to the patient who is already on medications for hypertension when she becomes pregnant?

Dr. Sanders: If the patient is already receiving antihypertensive drugs before pregnancy I continue them. In the untreated patient, if the blood pressure is chronically elevated over 140/90 mmHg, I use drug therapy, generally in the form of methyldopa. I normally attempt to avoid diuretic therapy after the twentieth week of gestation.

Dr. Rivlin: What are the problems associated with chronic hypertension in pregnancy?

Dr. Blackburn: Small for gestational age infants, an increased risk of abruptio placenta, and a poorer neonatal outcome which in general correlates with the severity of hypertension are problems. Failure to record a fall in blood pressure during the second trimester may be prognostic. The most common problem, of course, is that 10-40% of patients with essential hypertension develop superimposed preeclampsia.

Dr. Rivlin: How do you diagnose superimposed preeclampsia?

Dr. Shields: This is relatively easy if you have been following the patient through her pregnancy. It is much more difficult if the patient presents to you in the third trimester. The presence of proteinuria and marked edema, together with a worsening in the blood pressure readings suggest the onset of superimposed preeclampsia. Danger signs include headache, epigastric pain, scotomata, decreased platelet counts and, of course, seizures.

Dr. Rivlin: What general measures do you carry out in managing your essential hypertensive patients as pregnancy progresses?

Dr. Sanders: I encourage bedrest throughout pregnancy if feasible, two hours in the afternoon and eight hours at night. I carry out maternal surveillance every week after 20 weeks gestation. For patients who are hypertensive and on medication, I commence fetal surveillance at 28 weeks gestation.

Dr. Rivlin: Our patient's history was so strongly suggestive of pheochromocytoma that we did stop the methyldopa and order VMA and metanephrine levels. In addition, T3, T4, TSH, calcium, calcitonin and parathyroid hormone levels were ordered. Thyroid and parathyroid function were evaluated because of a clinical constellation called multiple endocrine adenopathy type II, or Sipple's syndrome, which is the triad of hyperparathyroidism, pheochromocytoma and medullary thyroid carcinoma. While rare, this syndrome must always be excluded when dealing with any of the components of the constellation. What investigations could be carried out in order to localize a pheochromocytoma if one is present?

Dr. Blackburn: Between 50-70% of pheochromocytomas are solitary and located in the adrenal gland. However, 5-25% are bilateral. The most accurate investigation is a computed axial tomographic (CAT) scan, but a sonogram may also be helpful.

Dr. Rivlin: Sonography revealed a 20.5 ± 1.6 week gestation. Both renal areas were scanned. Inferior to the lower pole of the left kidney was a mass measuring 5-7 cm in diameter with a well demarcated border (see Figure 1). Two days after admission, the patient underwent a prolonged episode of hypertension (200/150) unresolved by hydralazine (Apresoline) 20 mg IM and 5 mg IV. This episode was associated with profuse sweating, nausea and blood-tinged vomitus. Because of the vomiting, the patient was also given promethazine (Phenergan) 25 mg IV. She was then noticed to be diaphoretic and have a pulse ranging up to 160 with an EKG revealing a sinus tachycardia.

Dr. Shields: Vasodilators such as hydralazine may give rise to reflex sympathetic activation in patients with unsuspected pheochromocytoma. Paradoxic hypertension then results. The literature documents some cases in which profound hypotension with shock and even demise have then followed the use of phenothiazine, so that it is important to keep a high index of suspicion for the presence of a pheo-

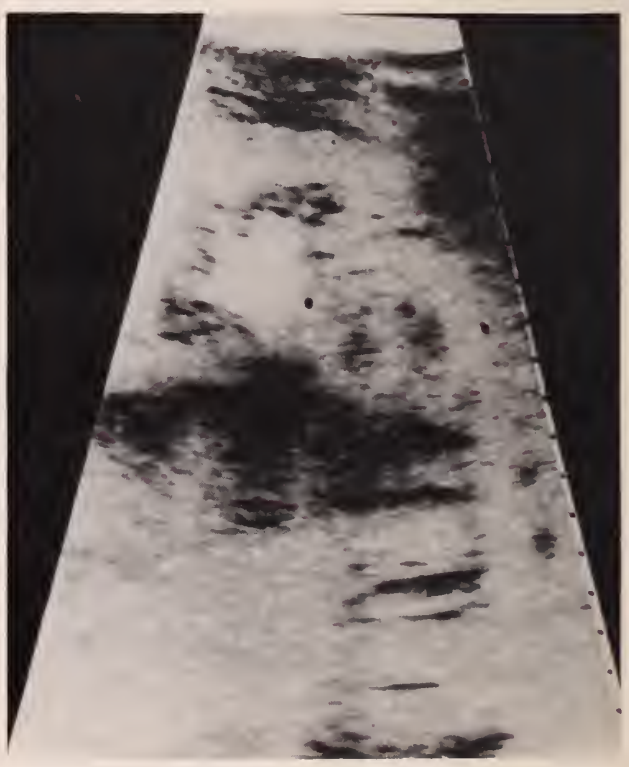


Figure 1. Marker on this ultrasound scan outlines mass with well-demarcated borders.

TABLE 1
CATECHOLAMINE RESULTS

Urinary catecholamines:	
VMA — Negative	
Urine metanephine 19.9 (N = 0.3-0.9)	
Urine total catecholamines 6509 (N = <115)	
Plasma catecholamines:	
Norepinephrine 35,660 pg/ml (N = 104-548)	
Epinephrine 300 pg/ml (N = 88)	
Dopamine 30 pg/ml (N = 136)	
Total catecholamines 35,990 pg/ml (N = 104-772)	

chromocytoma which may mimic toxemia of pregnancy.

DR. RIVLIN: In view of the very strong clinical evidence of a pheochromocytoma, therapy was commenced with phenoxybenzamine (Dibenzyline) 10 mg po to be repeated in six hours, then tid. There was rapid improvement. The blood pressure was 100/70 and pulse was 130. No further nausea or vomiting was noted. The next day propranolol (Inderal) 20 mg po tid was added to this regimen. There were no further episodes of hypertension. The diastolic blood pressures remaining at about 80 mmHg and pulse under 100. Why must alpha-blockade precede beta-blockade?

DR. SANDERS: If alpha receptors are not first blocked, beta-blockade may result in a severe rise in blood pressure and pulmonary edema. Therefore, phenoxybenzamine (an alpha-blocker) is given first, followed by propranolol (a beta-blocker). What were the results of your studies?

DR. RIVLIN: Thyroid and parathyroid studies were normal. Results of catecholamine studies are shown in Table I. These tests were definitive for pheochromocytoma other than the VMA result which was almost certainly erroneous.

DR. BLACKBURN: We have clearly established the presence of a pheochromocytoma and the sonogram appears to have localized the tumor. An interesting point to keep in the back of one's mind is the condition of pseudopheochromocytoma associated with the ingestion of sympathomimetic compounds found in a variety of easily accessible medications including decongestants, anorectics, and stimulants. If for some reason the patient conceals ingestion of such compounds or it is missed in the history, the condition may mimic a pheochromocytoma closely and may even be associated with cardiac arrest. Toxicology is required to confirm the diagnosis.

DR. RIVLIN: The patient did undergo abdominal CAT scan. The reason for the further study was to

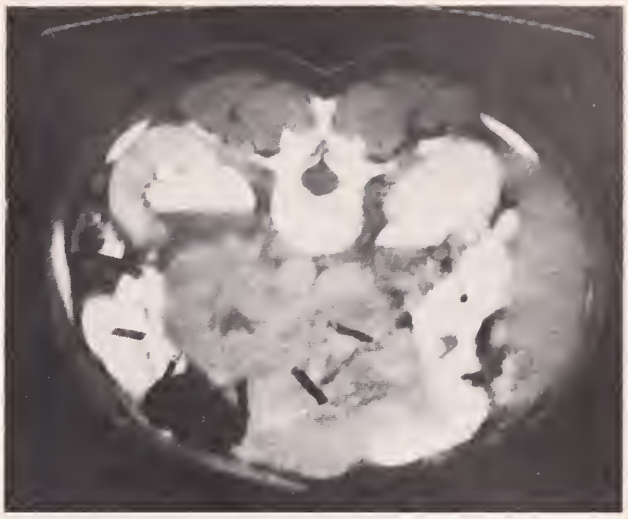


Figure 2. Marker on this computerized axial tomographic scan outlines mass medial to the kidney.

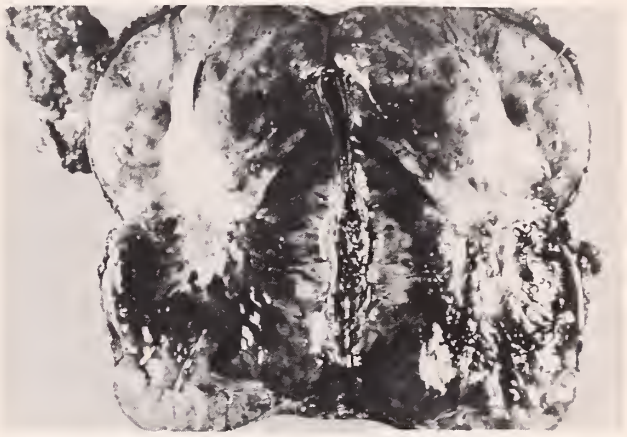


Figure 3. Gross appearance of tumor and normal adrenal gland.

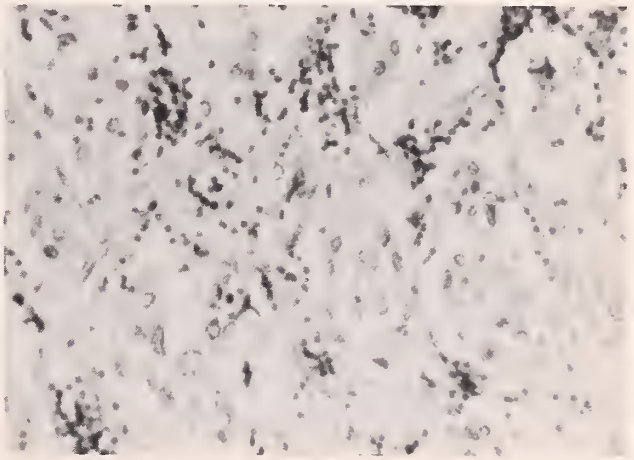


Figure 4. Microscopic appearance of tumor. Note the bizarre shapes of the chromaffin cells and the marked vascularity of the neoplasm.

exclude the presence of multiple tumors especially the other adrenal. The scan showed a mass medial to the left kidney extending from the inferior margin of the pancreas to the lower pole of the kidney (see Figure 2). When do you recommend surgical removal of the tumor?

DR. SANDERS: Adequate sympathetic and parasympathetic blockade must first be obtained, and then in late pregnancy, I would recommend removal of the tumor together with cesarean section delivery once fetal maturity has been confirmed. In early pregnancy, surgery should be carried out as soon as adequate blockade is obtained, since optimal results have been described with this approach.

DR. RIVLIN: At operation, a tumor was found anterior to the left renal pelvis extending caudad. During tumor handling, the patient became hypertensive but this was readily controlled. The right adrenal was found to be normal and a left adrenalectomy was performed with excision of the tumor. The postoperative course was benign with no evidence of premature labor. The histopathologic report of the tumor was that of an encapsulated extra-adrenal pheochromocytoma (paraganglioma), which was not attached to a normal adrenal gland (see Figures 3 and 4). Following surgery the patient became normotensive without further medication. As a final note, she delivered a male 2440 gm infant at term without complications.

Thank you for visiting with us today. I would like to acknowledge Dr. James Maher of the Department of Surgery at the University Medical Center, who was responsible for the surgical management. ★★★

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The President Speaking

Doctors and Politics

W. JOSEPH H. BURNETT, M.D.
Oxford, Mississippi

Last year our president stated, "none of us likes having to get into the health insurance business," referring to our statewide HMO/IPA. I also hear from different members, "I don't like having to be involved in politics." Although we'd prefer not to have to be involved, many of our members have recognized the inevitability of involvement in some form of alternate health care delivery system. It is similarly necessary for us to be involved in politics.

I have expressed to many of you my feelings that MSMA is evolving from an organization providing CME to an organization dealing with the socio-economic and political problems of our members. As long as I have been involved with MSMA, this has become more apparent every year. Many of MSMA's efforts to deal with socio-economic and political problems have been successful — some need our continued efforts.

From the national level, through AMA, we continuously deal with Medicare problems. Indeed, as a result of AMA's efforts and those of Mississippi's Congressional delegation, mandatory assignment was defeated. This required a great deal of political involvement!

At the state level we have enjoyed successes in lowering the statute of limitations on liability cases, for instance, along with other successes.

For the past several years MSMA has been sensitive to the need for a tort reform bill. In our attempts to bring about reform we have had setbacks which are to be expected when you consider the fact that attorneys control several legislative committees, etc. However, with the spread of the "liability crisis" in the business community, we have new allies across the state and the country.

Last year our membership was polled and approximately 200 members (less than 10%) came forward to volunteer some of their time, go to the capitol, etc. if necessary. It was decided the membership was not strongly enough behind a tort reform bill and, indeed, it died in the judiciary committee. As you may know, the judiciary committee blamed the insurance companies for not providing proof of losses in their liability coverages. To you and to me "getting out of the liability business" says a lot about profit and loss.

(Continued on page 323)

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XXVII, NUMBER 12
DECEMBER 1986

A Classic Case Of Over-Utilization

I am about ready to wail along with Chris Kristofferson "Why Me, Lord." It seems at my tender age I am repeatedly exposed to the seamy side of the practice of medicine.

I suppose that I take after my father, who was a born fox hunter and who firmly believed that there was no such thing as a sorry (dishonest or immoral) fox hunter. I guess I always felt that the mantle of medicine on our shoulders automatically conferred a trust that came with the territory! It is kind of rough to become disillusioned at this stage of the game.

As chairman of the Claims Committee of the MSMA Benefit Plan and Trust, I want to clue you in to a happening a few weeks ago in which two of our members were guilty of billing their own insurance company. A family member of an insured physician underwent treatment for which no fee was charged. Professional courtesy! What follows is neither professional nor courteous. The family member called our Plan Administrator and demanded payment be sent to them. This was refused since there was no bill from the attending physician. The insured physician then prevailed on the attending physician to submit a bill which was, by the way, stratospheric. And this was duly paid.

This is classic over-utilization which invariably causes higher premiums for us all — thus, destroying one of the main attractions of our company.

Our most competent Plan Administrator can only do so much to keep utilization down. Now we members must take part of the responsibility.

ARTHUR A. DERRICK, M.D.
Associate Editor

The President Speaking

(Continued from page 322)

So here is the triangle: the insurance companies in one corner, the judiciary committee and the trial lawyers in one corner, MSMA and our new allies in the other corner. MSMA has been encouraged by support in the legislature, but how do we get this out of committee and passed by the legislature? *Doctors and politics* — our personal involvement and influence is the only way.

One good friend told me last year "that's what I pay dues for, so we can hire someone to do this for us." If this attitude prevailed in our organization, we certainly would never enjoy political successes. However, a certain degree of apathy or distaste for political involvement seems apparent. "Doctors marching to the Capitol" is distasteful to me, also, but it apparently worked in Missouri and Florida. What do you think will work in Mississippi?

I propose we direct our legislative council to now utilize the auxiliary's telephone network and the physician key-contacts program to contact every member of the legislature before the next session begins. Further, I propose we poll our membership again, and if aggressive, supportive responses are obtained from 30% or more, MSMA put its concerted effort yet behind legislative relief for the malpractice crisis. Are reforms in several areas needed? Do you support this proposal?

Medico-Legal Brief

Patient Not Abandoned By Physician Or Hospital

A patient failed to state a prima facie case of abandonment against a physician and a hospital, the highest court of the District of Columbia ruled.

The patient went to the hospital emergency room because of rectal bleeding. She was admitted to the hospital as a patient of her regular attending physician. After two diagnostic procedures were performed, the physician scheduled her for a protosigmoidoscopy, possible polypectomy, and possible hemorrhoidectomy.

When presented with a constent form for these procedures, the patient refused to give her authorization. She continued to refuse after discussions with the physician and a hospital administrator. The physician said that he would release the patient from his services, and she was provided with a list of

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physicians whom she could contact. The physician she chose was unable to go to the hospital because of illness. She then contacted a physician who had treated her previously and discharged herself from the hospital.

The patient brought an action for malpractice, claiming abandonment. The trial court granted motions for summary judgment by the physician and hospital.

Affirming a summary judgment against the patient, the appellate court denied her contention that she had been left in the hospital without a replacement physician. The court said that there was no factual dispute as to how the physician-patient relationship was terminated. The physician and hospital assisted the patient in finding another physician, and she was not denied medical attention at any time. Her own expert testified that the medical care provided was appropriate and that the physician and hospital handled the dispute according to accepted standards of medical care. The court said that if a patient was not in need of immediate medical attention, supplying a list of physicians to replace the attending physician was a reasonable means of severing the professional relationship. — *Miller v. Greater Southeast Community Hospital,* 508 A.2d 927 (D. of C. Ct. of App., May 9, 1986)

POSTGRADUATE CALENDAR

January

ADVANCED CARDIAC LIFE SUPPORT PROVIDERS COURSE
Jan. 30-Feb. 1
University Medical Center

February

SURGICAL FORUM XIV
Feb. 18-21
Ramada Renaissance Hotel, Jackson

ADVANCED TRAUMA LIFE SUPPORT PROVIDERS COURSE
Feb. 26-27
University Medical Center

For more information or a program brochure, please contact the UMC Division of Continuing Health Professional Education at the University of Mississippi Medical Center, 2500 North State Street, Jackson, Mississippi 39216-4505; or call (610) 984-1300.

MEDICAL ORGANIZATION

MSMA HMO/IPA Board Signs Management Contract

The Board of the MSMA-sponsored HMO/IPA has signed a management contract with Physicians Health Management Corporation (PHMA), a subsidiary of Physicians Health Plan of Ohio, which operates a large and successful IPA in that state.

Staff of PHMA will immediately begin operations in Mississippi and a series of meetings for MSMA members will be scheduled throughout the state in early 1987 to discuss the activities of the Mississippi HMO/IPA.

Members of the Board of the HMO/IPA are: Drs. David R. Steckler, Natchez; Robert Allen Smith, Jackson; W. Lamar Weems, Jackson; W. Wade Dowell, Indianola; F. Earl Fyke, Jr., Jackson; William C. Gates, Columbus; Roy D. Duncan, Pascagoula; D. Stanley Hartness, Kosciusko; A. Jerald Jackson, Hattiesburg; and Robert M. Graham, Meridian.

HPA Final Report To Be Released in January

The American Medical Association has announced that the final report of the Health Policy Agenda for the American People is scheduled to be released in January 1987.

HPA represents a four-year cooperative effort by more than 150 organizations, including the AMA, to bring reason and purpose to the nation's health care policy-making process. The project was initiated in July 1982 and has involved 350 individuals representing health professionals, hospitals and other facilities, insurance providers, the pharmaceutical industry, state and federal government, business and consumer groups.

The HPA final report will provide the nation with a comprehensive framework for current and future policy development in the areas of medical science, health professions education, health resources, health delivery mechanisms and processes, evaluation and payment for service.

Dr. Tom H. Mitchell of Vicksburg, the chairman of MSMA's Council on Medical Service which has been reviewing the tentative HPA report, stated "the HPA is a comprehensive resource and policy document on health care which will have an impact in Mississippi and throughout the country." The council on Medical Service will recommend action on the HPA to the MSMA House of Delegates at its June 1987 meeting.

In its final form the HPA will be a two-volume report. Volume I will include an executive summary, an overview of the project with basic themes addressed in the report, and a narrative section that will embody the policy recommendations. Volume II will consist of background or reference material in the form of the original policy recommendations, rationales, and implementation plans.

Currently, 38 proposals have been tentatively approved by the HPA Steering Committee. The committee spent its September and October meetings reviewing and approving the final report.

A policy planning endeavor of this magnitude, bringing together such a diverse group of individuals and organizations, has not previously been attempted by the private sector. It will provide a common, national basis for responding to social, economic, scientific, educational and political issues as they affect the health care system.

Dr. McLain Named MFMC Medical Director

A Tylertown family physician, Dr. Jim McLain, has assumed the post of full-time medical director for the Mississippi Foundation for Medical Care.

Dr. McLain began his new duties on November 3. He succeeds Dr. J. S. McIlwain of Clinton, who has served for several years as part-time medical director.

Dr. McLain, a physician reviewer for MFMC for many years, had been engaged in private practice in Tylertown for 30 years.

JOIN MPAC TODAY

UMC Announces Faculty Appointments

Six have been named to the medical, health related professions and centerwide faculties at the University of Mississippi Medical Center for the current academic session.

Dr. Norman C. Nelson, UMC vice chancellor for health affairs, announced the appointments following approval by the Board of Trustees of State Institutions of Higher Learning.

School of Medicine faculty includes Dr. Barbara G. Love, instructor in pediatrics; Thomas P. Smith was named instructor in medical record administration in the School of Health Related Professions; and centerwide, Dr. David G. H. Bernanke and Dr. Paul J. May were named assistant professors of anatomy.

Dr. Love, who has been pediatric educational coordinator at the Medical Center since September 1986, earned the B.A. in 1974, the M.Ed. in 1975, education specialist certification in 1979, and the Ph.D. in 1985 at Mississippi State University. She did her postdoctoral internship in special education at the Kennedy Institute for Handicapped Children, and was a special education teacher and psychological examiner for the Kosciusko Municipal Separate School District from 1976-1979.

Smith, who is assistant professor of clinical pharmacy and director of pharmacy services at University Hospital, earned the B.S. in 1973 at Ole Miss and the M.S. in pharmacy administration in 1978 at the University of South Carolina. He did his residency in pharmacy administration with the American Society of Hospital Pharmacists at Richland Memorial Hospital in Columbia, South Carolina, where he was assistant director of pharmacy from 1977-1981. Smith has been a pharmacist in Tupelo and Brookhaven and was instructor in pharmacy at the University of South Carolina College of Pharmacy from 1975-1976, and director of pharmacy at Anderson Memorial Hospital in Anderson, South Carolina, from 1981-1985.

Dr. Bernanke earned the B.A. in 1972 at Duke University. He attended the Medical University of South Carolina and earned the Ph.D. in 1970 at Texas Tech University Health Sciences Center. He did his fellowship at Massachusetts General Hospital and Harvard Medical School. Dr. Bernanke, who has been instructor in gross anatomy at Harvard and instructor in pathology at the Wound Healing Laboratory of Shriners Burns Institute at Massachusetts General Hospital in Boston, was research associate in anatomy at Texas Tech University Health Sciences Center from 1979-1980, instructor in anatomy and physiology in the U.S. Army Reserve Basic Medical Training Program in Lubbock, Texas, from 1976-1978, and a biochemical research assistant in clinical pathology and biochemistry at the Medical University of South Carolina from 1972-1974.

Dr. May earned the A.B. in 1976 at Brown University and the Ph.D. in 1983 at Duke University. He has been a postdoctoral fellow in physiology and biophysics at New York University Medical Center since 1983.

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Season's Greetings

From the
MSMA Auxiliary Board and Past Presidents
On behalf of the AMA-ERF



May the warmth and good will of the season be yours

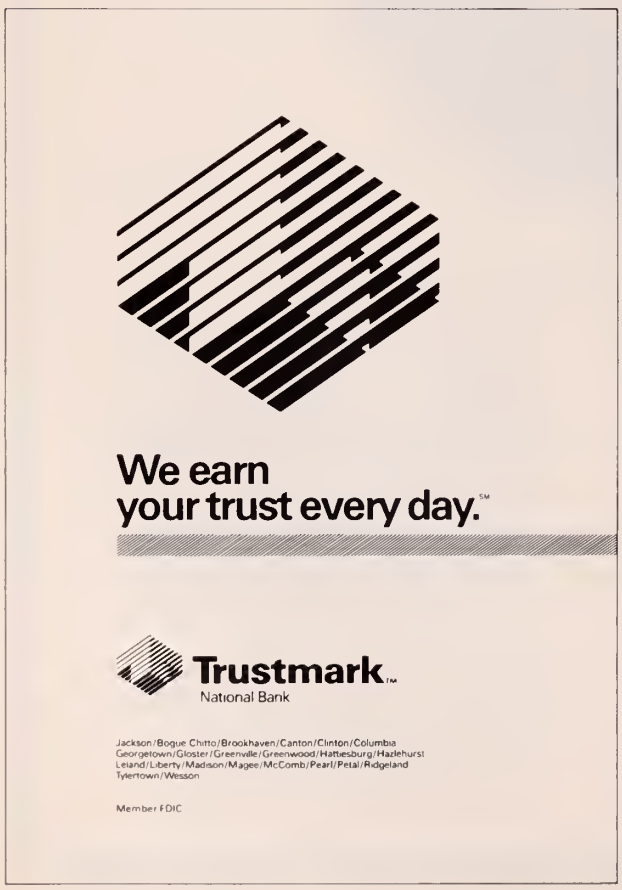
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Mrs. Benton Hilbun (Lucy)
Mrs. Edward Hill (Jean)
Mrs. Eric Lindstrom (Nancy)
Mrs. Ben Martin (Linda)
Mrs. David Owen (Sara Ann)
Mrs. George Owen (Ruth)
Mrs. Dale Russwurm (Teresa)
Mrs. Walter Shelton (Beverly)
Mrs. Doyle Smith (Ruth)
Mrs. A. T. Tatum (Martha)
Mrs. J. T. Thompson (Elizabeth)
Mrs. B. L. Walker (Sylvia)
Mrs. Henry Webb (Barbara)
Mrs. George Wilkerson (Pam)

NEW MEMBERS

BROSS, MICHAEL H., Jackson. Born Norman, OK, June 27, 1953; M.D., University of Oklahoma College of Medicine, Oklahoma City, 1979; interned and family practice residency, Area Health Education Center Family Practice, University of Arkansas, Pine Bluff, 1979-82; elected by Central Medical Society.

BROWN, NATHANIEL, Cleveland. Born Mound Bayou, MS, May 30, 1954; M.D., University of California College of Medicine, Irvine, 1980; interned and family practice residency, Los Angeles County Medical Center, Los Angeles, 1980-83; elected by Delta Medical Society.

BURNHAM, WM. DARRELL, Hattiesburg. Born Laurel, MS, Aug. 31, 1957; M.D., University of Mississippi School of Medicine, Jackson, 1983; interned and anesthesiology residency, University of Texas Medical Branch, Galveston, 1983-86; elected by South Mississippi Medical Society.



CARR, JAMES HENRY, Jackson. Born Brookhaven, MS, Oct. 4, 1957; M.D., University of Mississippi School of Medicine, Jackson, 1983; interned and internal medicine residency, University Medical Center, Jackson, 1983-86; elected by Central Medical Society.

DAVID, J. BERT, Jackson. Born Prentiss, MS, Oct. 29, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned and otorhinolaryngology residency, University of South Florida Medical Center, Tampa, 1980-85; elected by Central Medical Society.

GUTTMAN, STUART T., Pascagoula. Born Chicago, Jan. 30, 1945; M.D, Hanyang University School of Medicine, Sungdong-Ku, Seoul, Korea. 1975; interned Little Company of Mary Hospital, Evergreen Park, IL one year; medicine and neurology residency, Wayne State University Hospital, Detroit, MI, 1976-79; medicine residency, one year, Henry Ford Hospital, Detroit, 1979-80; elected by Singing River Medical Society.

HEYER, RICHARD L., JR., Tupelo. Born Corinth, MS, Jan. 10, 1957; M.D., University of Mississippi School of Medicine, Jackson, 1983; interned and anesthesiology residency, University Medical Center, Jackson, 1983-86; elected by Northeast Mississippi Medical Society.

MANSEL, J. KEITH, Jackson. Born Vicksburg, MS, Feb. 9, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned, internal medicine and pulmonary disease residency, Mayo Clinic, Rochester, MN, 1979-85; elected by Central Medical Society.

MILNER, GARLAND K., Jackson. Born Ft. Benning, GA, Dec. 6, 1952; M.D. University of Mississippi School of Medicine, Jackson, 1978; interned and anesthesiology residency, University of Texas, Galveston, 1978-81; elected by Central Medical Society.

OAKES, W. THOMAS, JR., Tupelo. Born Ackerman, MS, Dec. 25, 1953; M.D, University of Mississippi School of Medicine, Jackson, 1982; interned and neurology residency, University Medical Center, Jackson, 1982-86; elected by Northeast Mississippi Medical Society.

SPENCER, JESSIE, M., Bay St. Louis. Born Charlotte, NC, May 17, 1954; M.D., Medical University of South Carolina, Charleston, 1981; interned and medicine residency, University Medical Center, Jackson, 1981-85; elected by Coast Counties Medical Society.


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PERSONALS

James Achord of UMC attended a meeting of the Council of Subspecialty Societies of the American College of Physicians in Philadelphia, Pennsylvania.

Marc Allen of Quitman has been recertified by the American Academy of Family Physicians.

Paul Allen of Pascagoula spoke on "Women's Health" at a local meeting of the Daughters of the American Revolution.

William E. Anderson, III of Greenwood has been named chief of staff at Greenwood-Leflore Hospital.

Orlando J. Andy of UMC presented a paper at the Pavolonian Society Meeting in St. Louis, Missouri.

W. O. Barnett, medical director of the Continent Ostomy Center in Jackson, sponsored an organizational meeting in Jackson for the Quality Life Association, a support group for individuals with continent intestinal reserviors. Sixty people from 13 states participated.

Pat Barrett of Jackson conducted a workshop of scoliosis for the McComb Junior Auxiliary.

Caroline S. Battles has associated with Family Medical Clinic in Gulfport.

Austin Boggan of Decatur recently was recognized for 25 years of continued membership in the American Academy of Family Physicians.

Jerry Breeland of Brookhaven has been named to the Advisory Board of Trustmark National Bank.

Edward E. Bryant of Kosciusko has been recertified by the American Academy of Family Physicians.

Darrell Burnham, Jeffrey M. Jekot, and A. Gordon Lyons have associated for the practice of anesthesiology at 2601 Mamie Street in Hattiesburg.

V. R. Burnham, Jr. of Clarksdale has been recertified by the American Academy of Family Physicians.

C. Ron Cannon of Jackson presented a paper at a meeting in San Antonio of the American Academy of Otolaryngology-Head and Neck Surgery.

Wilfred Q. Cole of Jackson recently was honored as a retiring member of the board of directors of the Mississippi State Health Department.

Laurie Cynthia Crowe announces the opening of her office for the practice of internal medicine at 346 Crossgates Boulevard in Brandon.

Martin Dalton of UMC presented a talk at the Maricopa Medical Center in Phoenix, Arizona.

Quinton H. Dickerson of Jackson recently received the Gold Heart Award presented by the American Heart Association in Mississippi. It is the association's highest award for service.

Michael Duckworth of Columbus was speaker at a meeting of the American Diabetic Association.

John Evans of Vicksburg spoke on osteoporosis at a women's health seminar at Vicksburg Medical Center.

George Gillespie of Jackson recently was honored by Mississippi State Hospital when he retired after 32 years of service.

James Hardy was interviewed by the British Broadcasting Corporation for a five-part documentary on the history of surgery. The series will appear in the U.S. on the Public Broadcasting System's "Nova" series next year.

Martin I. Herman of Tupelo has been accepted as a member of the American College of Emergency Physicians.

Wood Hiatt of UMC represented the Mississippi Psychiatric Association at a meeting in Atlanta of the Southern Regional Council of the American Psychiatric Association.

Benton M. Hilbun of Tupelo has been reappointed to the Mississippi State Board of Health.

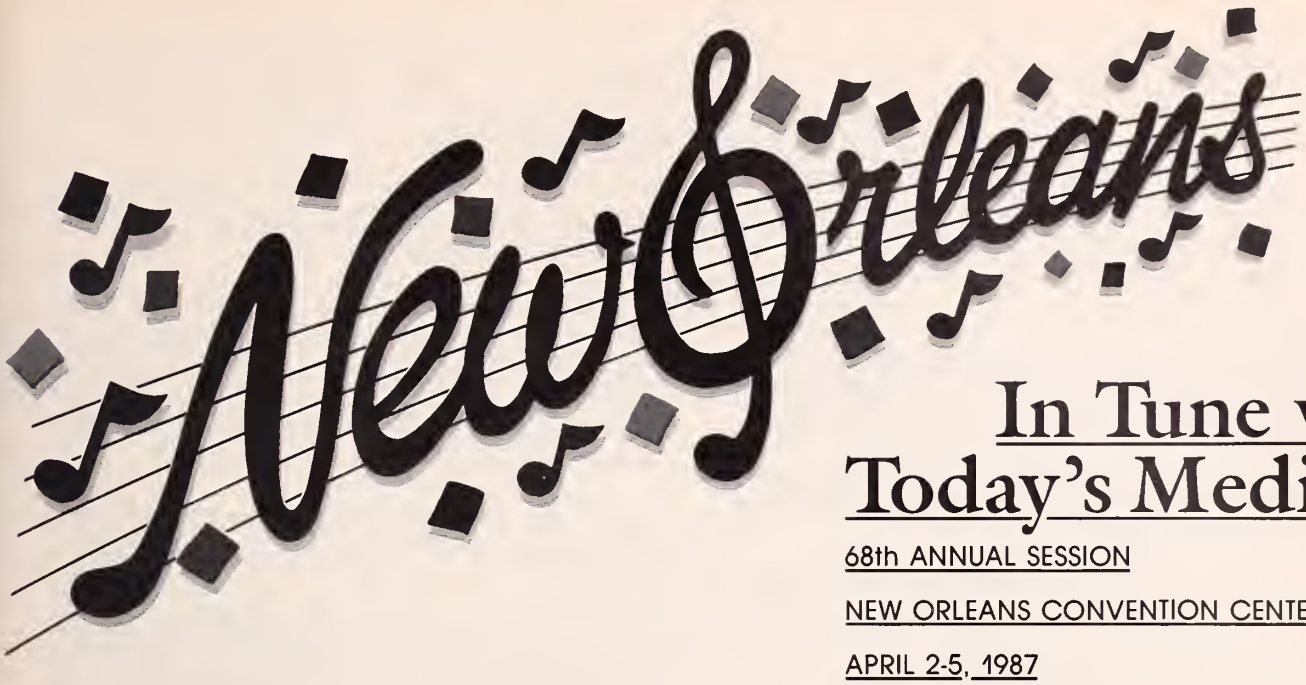
James L. Hughes of UMC served on the faculty of Midwest Regional AO/ASIF Orthopedics Instructional Workshop in Chicago and also served on the faculty for an AO/ASIF basic course in Jeffersonville, Vermont.

Whitman B. Johnson of Clarksdale has been named president and chairman of the Medical Staff Executive Committee at Northwest Mississippi Regional Medical Center. Travis Yates has been named vice-president and president-elect.

John W. McFadden of Tupelo made a presentation at the scientific meeting of the American Academy of Neurological and Orthopaedic Surgeons in Las Vegas.

(Continued)

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Gov. Bill Allain has appointed ALBERT L. MEENA of Jackson, MATTHEW J. PAGE of Greenville, and PAUL H. MOORE, SR. of Pascagoula to six-year terms on the Mississippi State Board of Medical Licensure.

JOSEPH S. MESSINA announces the opening of his office for the practice of internal medicine at 965 Avent Drive in Grenada.

FRANK J. MORGAN of Jackson has been reappointed as executive officer of the Mississippi State Board of Medical Licensure.

J. ELMER NIX of Jackson recently was named president of the North American Spine Society and its annual meeting at Lake George, New York.

FRANCIS S. MORRISON of UMC, recently named chief of staff of University Hospital, has been elected president-elect of the South Central Association of Blood Banks.

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DANIEL T. OVERBECK has associated with Garden Park Outpatient Clinic in Gulfport for the practice of internal medicine.

PAUL F. PARKS, JR. has associated with Gulfport Orthopedic Clinic, 4502 West Railroad Street, for the practice of orthopedic surgery.

WESLEY F. PRATER announces the opening of his office for the practice of obstetrics and gynecology at 207 West Water Street in Carthage.

WILLIAM ROBINSON has opened his office for the practice of general surgery in Lucedale.

GUS A. "SONNY" RUSH of Meridian has been named a diplomate of the American Board of Orthopedic Surgeons.

KELLY S. SEGARS, SR. of Iuka recently received the annual patient education award from *Patient Care*, a national journal for primary care physicians.

CLINTON H. SHARP, III has associated with Family Medical Clinic of Gulfport for the practice of family medicine.

PERRIN N. SMITH and CHARLES D. MILES of Columbus announce the association of GREGORY W. CHILDREY for the practice of obstetrics and gynecology at Columbus Women's Clinic.

LUTHER P. STUMME announces the opening of his office for the practice of neurology at 812 Garfield Street in Tupelo.

WILLIAM A. SPENCER of Oxford has been named chairman of the board for the North Central chapter of the American Diabetes Association.

W. GRANVILLE TABB, JR. has associated with CURTIS D. WHITTINGTON, JR., 1151 North State Street in Jackson, for the practice of general ophthalmology and ophthalmic surgery.

DAVID THOMAS of UMC was a delegate at the 30th annual meeting of the American Society of Internal Medicine in Seattle.

LAMAR WEEMS attended the Council on Hospital Medical Staffs meeting of the American Hospital Association in Chicago and a planning session for the annual meeting of the American Association of Clinical Urologists in Dallas.

WINFRED WISER of UMC was in Biloxi in September to present a lecture at Keesler Air Force Base.

INDEX
VOLUME XXVII

January-December, 1986

SUBJECT INDEX

The letters used to explain in which department the matter indexed appears are as follows: "A," Abstract; "E," Editorial; "N," News; "L," Letters to the Editor; "PP," President's Page; "RS," Radiologic Seminar, "BR," Book Review; "MLB," Medico-Legal Brief; "AP," Auxiliary Page; "C," Comment; "S," Special Article; the asterisk (*) indicates an original article in the Journal, and the author's name follows the entry in brackets. "Deaths," "Personals," and "New Members" are indexed under the letters "D," "P," and "M" respectively.

Matter pertaining to MSMA is indexed under "Mississippi State Medical Association."

A

Abdomen
evaluation of abdominal pain in children [Parker] 131-A
Abortion
concerning individual rights: letter comments on abortion [Mitchell] 166-L
MD liable for failing to get parental consent for abortion on minor, 304-MLB
reader disagrees with Dr. Gunter's comments on abortion [Campbell] 166-L
termination of pregnancy [Gunter] 72-C
Acromegaly
acromegaly: a case report [Wells] *9
American Medical Association
health policy agenda to be released January 1987, 325-N
letter identifies additional Mississippi physicians who are delegates to AMA from their specialty organizations [Moffitt] 246-L
presidents's page commends AMA delegation [Burnett] 188-PP
American Society for Gastroenterology
statement on granting hospital privileges to pe 'orm gastrointestinal endoscopy [Long and Spence] 96-S
Aneurysm
ruptured thoracic aortic aneurysm with aorto-esophageal fistula [Dalton et al] *1
Artery
adventitial cystic disease of the popliteal artery [Burkhalter and Connors] *215
radiological seminar CCXLIV: digital subtraction angiography in the diagnosis of subclavian steal [Morano et al] 89-RS
Auxiliary to MSMA
convention program, 135-AP
holiday sharing card (AMA-ERF), 327-AP
project provides medi-cards for patients, 101-N
reaching out is year's theme [Martin] 21-AP

B

"Baby Doe"
decision clarifies responsibility in treatment decisions [Lockey] 221-E
Blake, Thomas
honored by Mississippi Orthopedic Society, 16-N
Blood
long term forzen storage of autologous blood [Morrison et al] 276-L

C

Cancer
inguinal aprocrine gland adenocarcinoma: case report [Field et al] *299
Mohs surgery in the treatment of skin cancer [Abide] *313
Cat Scratch Disease
cat scratch encephalopathy [Wright et al] *29
Carotid Body
carotid body tumors [Defore] *155
Chest
experience with methacholine inhalation challenge in the evaluation of chest symptoms [Salter] *5
Chiropractic
Blue Shield must pay for chiropractic treatment, court rules, 176-MLB
Colitis
the continent jejunal reservoir in Crohn's colitis [Barnett]*119
Continuing Medical Education
postgraduate calendar listings on 52; 74; 146; 257; 280; 380
Coronary Artery Disease
repeat aortocoronary bypass: indications and results [McMullarn and Kilgore] *61
Crenshaw, C.P.
report of death, 137-N
Cyanide
UMC scientists seek patent for cyanide poisoning antidote, 305-N

D

Deaths
Crenshaw, C. P.
Egger, John G., 50
Green, George W., Jr., 282
Hill, Stanley A., 231
Hollingsworth, Jeff F., 173
Howorth, Beckett, 249
Koumjian, Kevin J., 282
Long, Lawrence W., 247
Neely, William A., 50
Pennington, Veronica, 231
Pittman, James J., 50
Powell, Joe, 249
Pruitt, Charles Jr., 231
Rush, H. Lowrey, Jr., 50
Simmons, William C., 173
Thompson, Robert Lewis, 50
Turner, Luther D., 249
Wiley, L. W., Sr., 50
Dermatology
tinea unguium (Daniel) *295
Mohs surgery in the treatment of skin cancer [Abide] *313
Dirofilaria Immitis
dirofilaria immitis as a cause of solitary pulmonary nodule [Holbert et al] *85
Drugs
adverse drug reaction reporting by Mississippi physicians [Juergens and Buchanan] *33
PADS program to control drug diversion, abuse, 106-N

E

Emergency Medicine
need for Good Samaritan legislation to protect physicians [Johnston] 43-E
pre-hospital emergency medical education [Jorden] 132-A
Encephalopathy
cat scratch encephalopathy [Wright et al] *29
Endocrinology
osteoporosis: benefits and risks of estrogen-progestogen replacement therapy [Gambrell] *267
Endoscopy
statement on granting hospital privileges to perform gastrointestinal endoscopy [Long and Spence] 96-S
Epiglottitis
epiglottitis in a community hospital [Coffey] *209
Esophagus
esophageal variceal sclerotherapy: UMC and Jackson VAMC experience 1980-1984 [Pace and Achord] *183
ruptured thoracic aortic aneurysm with aorto-esophageal fistula [Dalton et al] *1

F

Fungus
tinea unguium [Daniel] *295

G

Gland
inguinal apocrine gland adenocarcinoma: case report [Field et al] *295
Gastroenterology
early diagnosis and management of bleeding Meckel's diverticula [Long] *149
statement on granting hospital privileges to perform gastrointestinal endoscopy [Long and Spence] 96-S
Gynecology
osteoporosis: benefits and risks of estrogen-progestogen replacement therapy [Gambrell] *267

H

Harrell, H. Cody
Commended for long and devoted service to association, 47-N
Health Care
"back to the future: president's page examines health care issues (Brock) 126-PP
health policy agenda to be released January 1987, 325-N
where did we go wrong? editorial examines issues [Derrick] 165-E
Health Insurance
Blue Shield must pay for chiropractic treatment, court rules, 176-MLB
Health Maintenance Organization (HMO)
(See MSMA HMO/IPA)
Heart
perioperative myocardial infarction [Lambert] *259
Home Health Services
need for review [Lockey] 275-E
reader comments on regulation of home health services [Kemp] 303-L
Hypertension
management of hypertension in early pregnancy [Rivlin et al] 317-S
rationale for drug selection [Cushman] 131-A

I

Ileostomy
the continent jejunal reservoir in Crohn's colitis [Barnett] *119
Indigent Care
indigent care — a view from the countryside [Jackson] 44-C
outstate neurology clinics for the medically indigent — a continuing need [Haerer] *65
Infertility
the University of Mississippi program of human in vitro fertilization and embryo transfer [Cowan et al] *291

L

Legislation
legislature considers bills on health issues, 47-N
litigiousness a sign of moral decay: editorial describes need for legislation limiting non-economic damages [Dabney] 71-E

need for Good Samaritan legislation to protect physicians [Johnston] 43-E
your involvement necessary for tort reform [Barnett] 241-PP
Long, Lawrence W.
funeral services held, 247-N
Lawrence Long will be missed [Dabney] 245-E
tribute to Dr. Long's contribution to Journal MSMA [Lockey] 101-E

M

Malpractice
Mississippi adopts national medical standards for measurement of medical malpractice [Causey] *68
litigiousness a sign of moral decay [Dabney] *71-E
Manpower
doctor shortage: rural health care solutions evasive, 127-E
Medicaid
Mississippi physician participation in Medicaid [Weaver et al] *159
McLain, Jim
named director of MFMC, 325-N
Medical Ethics
"Baby Doe" decision clarifies responsibility in treatment decisions [Lockey] 221-E
withholding or withdrawing life prolonging medical treatment: opinions of the AMA Council on Ethical and Judicial Affairs, 221-MLB
Medical Practice
high finance [Johnston] *303-E
high tech in rural Mississippi [Johnston] *189-E
letter comments on editorial about in-office laboratory testing [Nicholas] 245-L
letter praises Dr. Derrick's editorial on changes in medical practice [Gough] 275-L
quality assurance: cost, legal and ethical issues [Thompson] 132-A
where we've been — where we're going [Burnett] 220-PP
Medico-Legal Briefs
accident victim's estate can sue physician of driver for malpractice, 204-MLB
AMA and Supreme Court decisions, 276-MLB
Blue Shield must pay for chiropractic treatment, court rules, 176-MLB
court awards parents $1 million for loss of consortium, 128-MLB
husband of Jehovah's Witness who refused blood transfusion sues physician for malpractice, 13-MLB
MD liable for failure to get parental consent for abortion on minor, 304-MLB
no restraint of trade by hospital that denied podiatrist staff privileges, 71-MLB
opinions of the AMA Council on Ethical and Judicial Affairs, 255-MLB
patient not abandoned by physician or hospital, 323-MLB
physician fee freeze for Medicare not unconstitutional, 45-MLB
university discriminated against female physician, court finds, 104-MLB
withholding or withdrawing life prolonging medical treatment, 221-MLB
Members, New
Alexander, Richmond L., III, 77
Allen, Paul M., 77
Al-Mefty, Ossama, 172
Arriola, Rodolfo N., 229
Ballard, James Lee, Jr., 172
Barr, William Michael, 77
Bedillion, T. Mark, 52
Benson, Chris H., 229
Blount, June G., 77
Borum, Charles D., 229
Bosscher, David B., 143
Bridges, William D., 281
Brihmadesam, L. J., 143
Brister, James C., 143
Bross, Michael H., 328
Brown, J. Arthur, 77
Brown, Nathaniel, 328
Bruce, David L., 230
Bruckmeier, Kurt F., 281
Brundage, Stephanie C., 143
Buckley, Neal W., 77
Burnham, William D., 328
Bydalek, Martin B., 77
Byrd, W. Hale, 52
Calhoun, Laurie, 77
Carpenter, Don E., 23
Carr, James Henry, 328
Cesare, C. David, Sr., 52
Clark, Alan J., 77
Connors, John J., III, 23
Cook, Harold E., III, 143
Cooley, Daniel Jay, 23
Crosby, Samuel Neil, 281
Danielson, Harry A., 143
Davis, J. Bert, 328
Davis, Nancy L., 77
Davison, James Marshall, 230
Dedeaux, Sidney J., 77
Devabhaktuni, P. K., 281
Dixon, Frederick E., 143
Dockery, Melissa H., 23
Duddleston, David N., 143
Durel, Cal, 230
Earley, Michael W., 143
Ellis, Terry K., 77
Ende, Maurice J., 77
Estess, Robert E., 23
Eyrich, George A., 77
Feldman, Arnold E., 230
Ferguson, Mitzi Gail, 23
Field, Richard J., III, 23
Fiser, H. Greg, Jr., 143
Folk, Ben P., III, 281
Frenz, John Allen, 230
Furr, Mack C., 143
Gandour, Michael J., 143
Garretson, Roland F., Jr., 23
Gerken, Maxine V., 172
Giffin, Robert Lee, 23
Gillespie, Dorothy, 281
Gillespie, H. L., Jr., 281
Gilliam, Larry S., 52
Goel, Dinesh K., 77
Gomez, Gloria, 230
Gore, Ney M., III, 78
Graham, Ronald A., 78
Griffin, T. David, 143
Grimes, Ben M., 23
Gutterman, John S., 23
Guttman, Stuart T., 328
Hankins, Randall R., 143
Hardey, Kim A., 78
Harris, James Earl, 230
Hayles, Kenneth J., 281
Hendrick, Richard G., 23
Henley, Felix T., 143
Henry, Michael A., 78
Henry, Susan E., 230
Hensley, Michael F., 230
Heyer, Richard L., Jr., 328
Hicks, W. Merrill, Jr., 230
Hilsman, Gray, 172
Hines, Brenda P., 23
Hodges, James M., 230
Hogan, Reed B., II, 23
Houston, Gerry Ann, 52
Hudson, Jim K., III, 172
Ireland, Robert B., Jr., 144
Jackson, Richard T., 230
Jekot, Jeffrey M., 281
Joiner, Thomas E., 52
Jones, James S., 78
Jones, Virginia A., 23
Joransen, James A., 78
Kahler, Ralph C., 281
Katz, Howard T., 172
Kees, Clarence, James, III, 172
Kellum, William Carl, Jr., 230
Kendig, Ronald J., 52
Knutson, Richard A., 78
Lambuth, Bruce W., 24
Land, Robert D., 172
LeBlanc, Michael H., 172
Leigh, Joe N., 79
Lewis, Robert L., 144
Lobrano, Charles M., 144
Long, Richard L., 24
Lowrimore, Marlin G., 281
Lucas, Phillip H., 24
Luciano, Vicente C., 282
Lyons, Alfred G., 282
Lyons, Reeda A., 52
Mangum, Charles S., 24
Mansel, J. Keith, 328
Maples, Michael D., 24
Marcy, William L., 230
Martin, Lawrence M., 79
Martin, Nancy S., 144
Martin, Rick W., 24
Martin, Sherry A., 282
May, Michael G., 79
McGraw, David B., 172
McLaurin, Clyde Ray, 230
Mehta, Usha J., 231
Miller, Jimmy D., 172
Milner, Garland K., 328
Mixon, James H., 172
Murphy, Harriet Ann, 79
Nayak, Mina C., 172
Neill, John C., 144
Newcomb, Martin M., 52
Nolan, Rathel L., III, 24
Oakes, W. Thomas, Jr., 328
Oostwouder, Peter H., 24
O'Sheal, Steven F., 24
Patel, Bharat R., 231
Pasco, Patrick J.,231
Peeples, Alan R., 24
Phillips, Clyde B., 79
Pisharodi, M. A., 24
Powell, Wiliam Edwin, 79
Powers, Robert E., 231
Preau, William J., III 144
Puckett, Cris G., 172
Purohit, P. R., 231
Purohit, R. C., 231
Randolph, Bruce W., 173
Randolph, Richard, C., 52
Reed, Alphonse M., 52
Richardson, Samuel M., III, 231
Rigdon, Edward E., 282
Roman, Jose L., 24
Ruth, Michael, 79
Schneider, Joseph F., Jr., 282
Segars, Kelly S., Jr., 79
Sherwood, Charles G., 79
Simmons, A. Larry, 173
Simo, J. Benjamin, 144
Smith, Andrea L., 231
Smith, Barbara H., 144
Smith, Donald K., 79
Smith, Glenn N., 144
Smith, L. Douglas, 24
Sorey, William H., 24
Spencer, Jesse M., 328
Stephens, David B., 79
Sy, Bertrand O., 144
Thomas, Dennis R., 173
Thompson, Phil D., 79
Tucci, James Michael, 282
Turner, Thomas A., 231
Ulmer, Jacob E., 231
Vandergriend, Robert A., 52
Walcott, Dexter, W., 231
Walker, Robert Lee, 144
Warrington, James E., Jr., 282
Weaver, Jason Michael, 282
Williams, Charles H., 24
Williams, Jesse C., 173
Williams, Robert Lynn, Jr., 282
Wilson, James P., 24
Wilson, Rhonda S., 24
Wright, Beenie B., Jr., 79
Yelverton, Richard L., 144
York, Milton R., 79
Menopause
management of menopause [Meeks et al] 122-GR
osteoporosis: benefits and risks of estrogen-progestogen replacement therapy [Gambrell] *267
Mississippi Academy of Family Physicians
announces new officers, 273-N
Mississippi Foundation for Medical Care
not a time to retreat [McIlwain] 127-C
Dr. McLain named new director, 325-N
Mississippi Orthopedic Society
honors Dr. Thomas Blake, 16-N
Mississippi State Medical Association
Bill Price joins staff, 247-N
Board of Trustees — holds winter meeting, 105-N; summer meeting, 272-N
Cody Harrell commended for service to MSMA, 47-N
construction of new headquarters: groundbreaking, 15-N; photos or progress 136-N
delegation meets with AMA executive committee, 249-N
hosts PADS coalition meeting, 106-N
HMO/IPA — reaches capitalization goal, 73-N; boards selecting management plan, 106-N; editorials urge members support, 42-PP; 13-E; 12-PP

nominees sought for Community Service award, 305-N
118th Annual Session — preliminary plans announced, 105-N; official call and complete program, 129 ff; complete report of, 191 ff; address of the president, 241-S
119th Annual Session — preliminary plans announced, 325-N
president's pages [Brock] "Hippocrates Revisited," 12-PP; "The Water's Fine," 42-PP; "Marry a Pharmacist's Daughter," 70-PP; "Grand-Slam Homer, 100-PP; "Back to the Future," 126-PP
[Burnett] "What Can We Do For MSMA?" 164-PP; "The Cream Always Rises to the Top," 188-PP; "Where We've Been — Where We're Going;" 220-PP; "Your Involvement Necessary for Tort Reform," 244-PP; "Let's Talk Budget," 244-PP; "Community Service," 302-PP;

N

Neurology
outstate neurology clinics for the medically indigent — a continuing need [Haerer] *65
Neurosurgery
craniocerebral trauma and the primary physician [Miller and Smith] *233
a unique cervical spine fracture-dislocation: A case report [Frothingham et al] *179
Obstetrics and Gynecology
management of ectopic pregnancy [Cowan et al] 39-S
management of menopause [Meeks et al] 122-S
management of hypertension in early pregnancy [Rivlin et al] 317-S
osteoporosis: benefits and risks of estrogen-progestogen replacement therapy [Gambrell] *267
the University of Mississippi program of human in-vitro fertilization and embryo transfer [Cowan et al] *291

P

Patients
patient not abandoned by physician or hospital, 323 MLB
Pediatrics
Cat scratch encephalopathy [Wright, et al] *29
epiglottitis in a community hospital [Coffey] *209
Personals
Abraham, George E., II, 205; 227
Achord, James, 18; 81; 109; 205; 227; 330
Adams, Thomas, F., 251
Aiello, Marilyn J., 109
Alcalen, Erlinda, 18
Alexander, J. Gilbert, 18
Alford, Tim, 251
Allen, Marc C., 330
Allen, Paul 330
Allen, Robert F., 310
Anderson, William E., III, 330
Andy, Orlando, 18; 55; 109; 175; 205; 251; 330
Ashford, William, 109
Balducci, Lodovico, 205
Ball, G. Christopher, 109
Ball, George W., 175
Barnett, W. O., 227; 287; 310; 330
Barrett, Gene, 141; 205; 227;
Barrett, Pat, 330
Bass, Edward J., 251; 287
Bates, William, 55; 81; 109; 175; 205
Batman, Anita, 56
Batson, Blair, 55; 81; 141; 251; 310
Battles, Caroline S., 330
Beghé, Claudia, 109
Benson, Chris H., 81
Bentley, James R., 252
Berryhill, G. O., 227
Bise, John R., 175; 205
Boggan, Austin, 227; 330
Boler, Michael, 18
Bomboy, David W., 310
Boronow, Richard, 109
Borum, Charles D., 287
Bowen, Mary Kathryn, 251
Bradford, Bert C., 81
Bradshaw, Frederick, 20
Bramlitt, E. E. 251
Brandon, Leonard H., 18; 251
Breeland, Jerry, 330
Bridges, Arnold, D., Jr., 251; 287
Brock, Ralph L., 227
Broom, Sarah J., 287
Broussard, Curtis Andrew, 227
Brown, Sidney O., 18
Bruckmeier, Kurt F., 251; 287
Brunt, Joel, 109
Bryant, Edward E., 330
Buckley, Robert, 310
Bullwinkel, Bruce, 251
Burk, John D., 205; 251
Burkhalter, James L., 287
Burnham, Darrell, 330
Burnham, V. R., 330
Burrow, Lamar, 141
Bush, George, 205
Butts, Donald H., 81
Byrne, George W., 251
Calcote, Robert W., 55
Caldwell, Wallace, 175
Cameron, Winston, 175
Campbell, Tommy J., 287; 310
Cannon, C. Ron, 81; 175; 330
Carroll, H. Reed, 55
Chauvin, J. C., 253
Chen, Ching J., 287
Childrey, Gregory W., 330
Chism, Jimmy R., 227
Cirilli, Michael J., 251
Clark, James 1., 253
Clark, Robert E., 227
Cleveland, Webster, 175
Cole, Wilfred Q., 330
Coltharp, J. Robert, 55
Conerly, Donald V., 81
Conerly, Wallace, 141; 175
Conn, Richard, 310
Conner, Weir, 18; 227; 287
Cook, Clayton, 109
Cosetino, Douglas, 56
Cowan, Bryan, 287
Craig, Vann, 55
Crawford, David, 18; 55; 109; 287
Crawford, Everett H., 81
Cromartie, A. Dean, 253
Crosby, Samuel J., 251
Crosby, Samuel N., 287
Crowe, Laurie Cynthia, 287; 330
Crowell, R. W., 18
Currie, D. Randall, 251
Dalton, Martin, 141; 205; 310; 330
Daniel, C. Ralph, III, 81
Daniel, Jack D., 227
Dapremont, Edgar, 18
Dauterive, Alton H., 251
Davis, Frank, 109
Davis, J. T., 18
Davis, J. T., Jr., 287
Day, Larry H., 55
Defraites, Emanual, 141
Dickerson, Quinton H., 330
Dillon, Iley, 310
Drake, John, 20; 142; 205
Draper, Edgar, 287
Duckworth, Michael, 330
Dudley, Patricia, 251
Eakes, David L., 251; 310
Easterly, Clay, 310
Ellis, George H., 205
Enger, Daniel J., 56
Evans, John, 227, 330
Evans, Owen, 18; 81; 175; 310
Evers, Carl, 175; 205
Field, Richard J., Jr., 141; 227
Fillingane, Sam, 81
Fly, J. D., 227
Flynt, Joel R., 253
Folk, Ben P., III, 251
Foose, Michael, 251
Fox, C. Earl, 81
Franklin, J. B., 287
Freeland, Alan E., 227
Frenz, John A., 141
Friedman, Charles, 109
Frothingham, Rodney E., 81; 109
Frye, Harry C., 251
Gabbert, Elmo, 205
Gamble, Hugh, 109
Gearhart, Judy, 175
George, Richard, 205
Gersh, Allen, 175
Gibson, John Y., 287
Gibson, William, J., 251
Gieger, Edward L., Jr. 287
Giffin, Lee, 141
Gillespie, George, 330
Gillespie, Hilton, 251
Gispen, Jean G., 310
Glasgow, Thomas S., 227
Glover, Jeffrey H., 252
Golden, Keith, 252
Gordon, James O., Jr., 205; 227
Goyer, Thomas E., 310
Griffith, James E., 20
Guess, Charles, 205
Guice, Chuck, 55
Haick, Alexander, Jr., 251
Hale, T. Eric, 81
Hamblin, O. Lynn, 18
Hardy, James, 81; 109; 205; 330
Harper, John R., 227
Harris, Joe T., 288
Harris, Jonathan, 287
Harris, J. Mark, 252
Harvey, Marvin V., 141
Hatcher, Delores Elaine, 310
Hawkins, Harold, 142
Hayles, Kenneth J., 227
Henderson, Julian, 81
Herman, Martin, I., 18; 330
Henderson, Julian, 81
Herman, Martin I., 18; 330
Herrington, Joe, 55
Hiatt, Wood; 205; 319; 330
Hicks, Jennifer O., 205
Hicks, John B., 252
Hidalgo, Edgardo C., 287
Higgins, Robert W., 252
Hilbun, Benton M., 227; 330
Hill, J. Edward, 56; 176
Hill, Julian B., 18; 141
Hines, Brenda, 251
Hodges, Jeff A., 18
Hollingsworth, Jeff, 55
Hooper, Pleasant F., 287
Hoover, Jack C., 81
Howell, Shelby, 141
Howland, Robert L., 205
Hudson, Jim K., 142
Hughes, James, 18; 56; 252; 287; 330
Hull, Calvin T., 109
Hull, Edgar W., 18
Ingram, Thomas E., 81
Irwin, David H., Jr., 81
Jabaley, Michael E., 18; 109; 142
Jackson, John, 56; 81
Jackson, William G., 227
Jekot, Jeffery M., 330
Johnson, Noel, 56
Johnson, Richard A., 227
Johnson, Samuel, 109; 142
Johnson, Whitman B., 330
Jones, Leslie L. 288
Judd, Thomas K., 18
Kahler, Ralph C., 252
Kahlstorf, Jack H., 142
Kahlstorf, William L., 288
King, Bobby, 252
Kirchner, Kent, 81
Kirkland, Kim, 20
Knight, Joel Martin, 288
Knox, Cecil, 81
Kuluz, Matthew, 82
LaGrone, Donald H., 109
Lake, Chester H., Jr., 253
Langford, Herbert, 110; 142; 176; 205; 252; 288
Lampton, T. D., 56
Lee, Robert, 251
Lehan, Patrick, 176
Lenoir, Leon, 251
Liddell, Hal Thompson, 252
Lindstrom, Eric, 288
Little, Robert A., 20
Lockey, Myron W., 176
Louis, Tom, 176
Lovelace, Mike, 287
Lowe, C. Foster, 110
Lowicki, Edward M., 110
Lyle, Ray, 82
Lyons, A. Gordon, 330
Mansel, J. Keith, 176
Martin, James, B., 20
Martin, Sherry A., 252
Mason, Gilbert, 227
Masterson, Chester, 252
McCaa, Connie, 205; 288
McClain, Eldon D., 56; 110
McCloskey, John, 205

McCraw, Barry, 227
McDonald, Judy L., 252
McFadden, John W., 252; 330
McGee, Hilda J., 253
McKell, William, 227
McLeod, Hugh C., 110
McMahan, Lynn B., 252
McMillan, Beverly, 227
McMullan, George, 110
Meena, Albert L., 330
Merlos, J. Ricardo, 20
Messina, Joseph S., 330
Middleton, Robert, 20
Miles, Charles D., 330
Milhorn, H.T., 288
Miller, Richard, 110
Millette, Theodore M., 18
Minder, Joseph K., 227
Mitchell, Don Q., 176
Mitchell, Tom, 310
Moak, Wilson, 110; 176
Moffitt, Ellis M., 56
Moffitt, Nina, 227
Moore, Paul H., Sr., 142; 330
Moore, T. L., Jr. 142
Morgan, Frank J., 330
Morris, Toxey, 310
Morrison, Francis, 20; 205; 330
Morrison, John, 82; 205; 288, 310
Moorhead, Robert J., 176; 227
Mundiger, G.H., Jr., 253
Murry, C. M., 110
Nayak, K. D., 253
Namihira, Yoshinobu, 288
Nicholas, William, 20; 110; 142; 176; 205
Nichols, Howard, 82; 206
Nichols, William K, 253
Nix, J. Elmer, 142; 330
Norman, Joe, 110
North, Darden, 227
Oakes, William T., Jr., 253; 288
O'Mara, Charles, 206
Oostwouder, Peter H., 20
Orr, Edwin, 228
Overbeck, Daniel T., 330
Overstreet, Raymond, 82
Pace, Mary E., 288
Pace, Samuel C., 253
Packer, Douglas, 253
Page, Matthew J., 330
Pandey, Shanti, 206
Parker, Judith, 228
Parkman, Charles J., 20; 228
Parks, Paul F., Jr., 330
Parvin, Steve, 142
Peacocke, Ivan L., 110
Pendergrass, John, 206
Pennebaker, James B., 81
Person, Brett T., 18; 110
Person, Milton T., 228
Petro, John V., 253
Pinkston, William C., 20
Platt, Lucas, 227
Porter, William C., 228
Prater, Wesley F., 330
Preau, William, 20
Pulliam, Joe, 253
Purdon, J. S., 288
Purvis, George, 20
Raju, Seshadri, 82; 176; 228; 310
Ramsey, Calvin 228
Rausa, Alfio J., 20
Regan, Teresa, 228
Richardson, David, 253
Richardson, Travis, 56
Rigdon, Edward E., 253
Robbins, Kenneth, 253
Robinson, William, 330
Roman, Jose, 109
Root, Benjamin A., 253
Rose, Walter, 253
Ross, Randolph, 142; 176; 227; 253
Rowlen, Dennis, 228
Runnels, G. O., 110
Runnels, R. S., 142
Rush, Gus A., III, 330
Russo, Lawrence J., 56; 206
Ruth, Michael, 18
Sabin, James, 110
Salter, Victor, 110
Sanders, Henry, 176
Sanford, Ben, 20
Schmidt, Robert J., 110
Schreiter, Spencer, 56
Segars, Kelly S., 56; 330
Sessums, M. Catherine, 253
Seyler, Cliff, 82
Shappley, Nathan, 142; 310
Sharp, Clinton H., 330
Shell, J. Robert, 82
Shell, John, 253
Short, Dwight, 142
Shumski, Edward J., 253
Slipman, Curtis W., 310
Smith, Andrea, 228
Smith, Barbara L., 20
Smith, Christopher, 228
Smith, Doyle P., 110
Smith, Perrin N., 330
Songharoen, Suthin, 253
Soriano, A. P., 56
Speed, J. Keith, 253
Spencer, William A., 227; 330
St. Clair, Arthur W., 82
Steckler, David, 253
Steiner, Albin, 288
Stevens, Thomas E., 110
Stewart, Edsel, 110
Stone, Van D., 228
Stripling, John, 311
Stroble, Charles, P., 20
Stubbs, Kenneth, 55
Studdard, John E., 176
Stumme, Luther P., 330
Tababbare, Toufik, 56
Tabb, W. Granville, 330
Talkington, James M., 253
Talkington, T. W., 253
Taylor, Horton, 228
Taylor, Max, 56; 206
Thigpen, Tate, 206
Thomas, David, 330
Thomas, Dennis, 206
Thomas, P. K., 228
Thompson, Ed, 311
Timm, David, 82
Tinsley, Plez, 311
Touchstone, William C., 311
Trapp, James T., 288
Tucci, James M., 253
Turner, Betty H., 253
Turner, Jackey D., 253
Tyler, Henry, 56
Valentine, J. Lee, 288
Valenzuela, Raul, 82
Vance, Ralph, 206; 228; 288
Vise, Richard, 206
Vogel, V. Frank, 288
Voyles, Randy, 20, 142
Vyas, C. K., 253
Walcott, Dexter Winn, 288
Walley, W. W., 253
Watson, Robert, 20
Wessler, Gerald, 20; 253
Weems, W. Lamar, 20; 56; 288; 311; 330
Wells, Ralph P., 288
Westbrook, Terry, 206
White, John J., 176
Whites, Barry L, 176
Whittington, Curtis D., 330
Wiggins, Chris, 206; 311
Wilder, S. J., 253
Williams, Charles O., 288
Williams, J. K., 311
Williams, Robert L., 176
Williams, Steven C., 206
Williamson, Stoney, 253
Wiser, Winfred, 56; 176; 206; 330
Wood, Eugene, 110
Wood, H. E., 287
Wooley, John R., 229

Peptic Ulcer
mortality in bleeding and perforated peptic ulcer [Hilbun et al] *237

Pharmacists
appreciate president's page article on prescribing habits [Moret] 165-L
marry a pharmacist's daughter [Brock] 70-PP

Physicians
"Baby Doe" decision clarifies responsibility in treatment decisions [Lockey] 221-E
"Back to the Future" — president's page discusses practice of medicine [Brock] 126-PP
"Bit By a What?" — patient's lion bite reminiscent of physician and government [Johnston] 245-E
the breaking of a surgeon [Cook] 102-C
community service [Burnett] 302-PP
doctor shortage: rural health care solutions evasive, 127-E
high finance [Johnston] 303-E
MD liable for failing to get parental consent for abortion on minor, 304-MLB
opinions of AMA Council on Ethical and Judicial Affairs, 255-MLB
patient not abandoned by physician or hospital, 323-MLB
university discriminated against female physician, court finds, 104-MLB
"Where Did We Go Wrong?" [Derrick] 165-E
"Where We've Been — Where We're Going" [Burnett] 220-PP

Pituitary
acromegaly: a case report [Wells] *9

Placement Service
listings on pages 28; 60; 84; 118; 148; 178; 208; 232; 257; 290; 311; 338

Podiatrist
no restraint of trade by hospital that denied podiatrists staff privileges, 71-MLB

Poisoning
UMC scientists seek patent for cyanide poisoning antidote, 305-N

Postgraduate Calendar
listings on pages 52; 74; 146; 257; 280; 308; 324

Pregnancy
management of ectopic pregnancy [Cowan et al] 39-S
management of hypertension in early pregnancy [Rivlin et al] 317-S
termination of pregnancy [Gunter] 72-C

Prescriptions
"Marry a Pharmacist's Daughter," president's page offers tips on safeguards and management of prescriptions [Brock] 70-PP

Professional Liability (see also Malpractice)
editorial describes need for legislation limiting non-economic damage awards [Dabney] 71-E
no-no's in medicine [Stennis] 132-A

Professional Review Organization
not a time to retreat [McIlwain] 127-C

Pulmonary Disease
dirofilaria immitis as a cause of solitary pulmonary nodule [Holbert et al] *85
experience with methacholine inhalation challenge in the evaluation of chest symptoms [Salter] *5

R

Radiological Seminar
CCXLIV: digital subtraction angiography in the diagnosis of subclavin steal [Morane et al] *89-RS

Radiology
adventitial cystic disease of the popliteal artery [Burkhalter and Connors] *215
MRI: current status and future promise [Miller] 131-A

Rape
Letter indentifies source of data on rape statistics [North] 246-L

S

Sclerotherapy
esophageal variceal sclerotherapy: UMC and VAMC experience 1980-1984 [Pace and Achord] *183

Skin
Mohs surgery in the treatment of skin cancer [Abide] *313

Spine
a unique cervical spine fracture-dislocation: case report [Frothingham et al] *179
Pott's paraplegia; case report [Frothingham et al] *263

Surgery
perioperative myocardial infarction [Lambert] *259
the breaking of a surgeon [Cook] 102-C

Surgery, Cardiovascular
repeat aortocoronary bypass: indications and results [McMullan and Kilgore] *61

T

Technology
high-tech in Mississippi: editorial discusses in-office testing [Johnston] 189-E

Tuberculosis
Pott's paraplegia: case report [Frothingham et al] *263

Tumor
carotid body tumors [Defore] *155

U

Ulcer
mortality in bleeding and perforated peptic ulcer [Hilbun et al] *237
University of Mississippi
medical alumni appoint four to board, 138-N
ob-gyn alumni elect officers, 170-N; establish Winfred L. Wiser Society, 170-N
University Medical Center
announces faculty appointments, 17-N; 73-N; 137-N; 223-N; 248-N; 305-N; 326-N
dedicates Beckett Howorth Orthopedic Library, 169-N
dedicates stained glass collection, 224-N
develops advanced communications system, 50-N
first birth for UMC in-vitro fertilization program, 137-N
honors retiring faculty member, Dr. William Wiener, 74-N
ob-gyn endowment committee meets, 279-N
presents awards to top graduates, 223-N, 224-N
pays tribute to 30-year clinical faculty, 48-N
scientists seek patent for cyanide poisoning antidote, 305-N

AUTHOR INDEX

The letters used to explain in which department the matter indexed appears are as follows: "A," Abstract; "C," Comment; "E," Editorial; "N," News; "L," Letters to the Editor; "PP," President's Page; "RS," Radiologic Seminar; "MLB," Medico-Legal Brief; "BR," Book Review; "AP," Auxiliary Page; "S," Special Article; the asterisk (*) indicates an original article in the Journal.

A

Abide, John M., *313
Abney, Robert L., 159-S
Achord, James L., *183

B

Banahan, Benjamin F., III, *33
Barnett, William O., *119
Bates, G. William, *291
Billups, Thomas K., *237
Blaylock, Darrell, *263
Brdlik, Charles J., 89-RS
Brock, Ralph L., 12-PP; 42-PP; 70-PP; 100-PP; 126-PP; 241-S
Burkhalter, James L., 89-RS; *215
Burnett, W. Joseph, 164-PP; 188-PP; 220-PP; 244-PP; 274-PP; 302-PP; 322-PP

C

Campbell, Robert, 166-L
Causey, Denzil Y., Jr., *68
Coffey, John D., Jr., *209
Conn, J. Harold, *1
Connors, John J., III, *215
Cook, Donald E., 102-C
Cowan, Bryan D., 39-S; *291
Cravens, Gail, *291
Cushman, William C., 131-A

D

Dabney, W. Moncure, 71-E; 245-E
Dalton, Martin, *1
Daniel, C. Ralph, III, *295
Defore, W. Wilson, *155
Derrick, Arthur A., 165-E; 323-E

E

Evans, Owen B., *29

F

Fiakow, Robert A., *179
Field, Richard J., Jr., *299
Field, Richard J., III, *299
Frothingham, Rodney E., *179; *263

G

Gamble, Hugh, *263
Gambrell, R. Don, 267-S
Gough, Walter C., 275
Gunter, Tom, 72-C

H

Haerer, Armin F., *65
Hamilton, Jimmy L., *237
Hilbun, Benton M., *237
Holbert, Robert D., *85

I

Isbell, Barry, *1

J

Jackson, A. Jerald, 44-C
Johnston, Joseph E., 43-E; 189-E; 245-E; 303-E
Jorden, Robert, 132-A
Juergens, John P., *33

K

Kemp, Mendal G., 302-L
Kilgore, Thomas L., *61

L

Lambert, Lee A., *259
Lockey, Myron, 13-E; 101-E; 221-E; 275-E
Long, Billy W., 98-S; *149
Lucas, John A., *291

M

Maher, David C., *299
Martin, Mrs. Ben F., 21-AP
McIlwain, J. S., Jr., 127-C
McMullan, Martin H., *61
McRae, John M., 166-L
Meeks, G. Rodney, 122-S; *291; 317-S
Miller, J. D., *233
Miller, Kenneth, 131-A
Mitchell, John E., 166-L; 166-C
Moffitt, Ellis M., 246-L
Moffitt, John, *29
Moret, Phyliss M., 165-L
Morano, James U., 89-RS
Morrison, Francis, 276-L

N

Newsom, Barry, *1
Nicholas, William C., 249-L
North, Darden H., 246-L

P

Pace, Samuel C., *183
Parker, Paul H., 131-A
Parks, Carolyn, *291

R

Rivlin, Michel, 317S
Robinson, William T., *85
Rose, Walter, *263

S

Salter, Victor E., *5
Samson, Roland, 276-L
Scripter, Lyman D., *85
Smith, R. R., *233
Soloman, Alexandre, *179; *263
Sopelak, Victoria M., *291
Spence, James E., 98-S
Stennis, Tom L., 132-A

T

Thompson, Richard E., 132-A

W

Watson, David G., 159-S
Weaver, Marcia, 159-S
Weaver, Robert B., 159-S
Wells, Willie L., *9
Whitworth, Neil S., *291
Williams, Jim, 276-L
Williamson, J. W., *237
Wiser, Winfred, *291
Wright, Anna, *29

TABLE OF PAGES

January . . . . . 1 to 28
February . . . . . 29 to 60
March . . . . . 61 to 84
April . . . . . 85 to 118
May . . . . . 119 to 148
June . . . . . 149 to 178
July . . . . . 179 to 208
August . . . . . 209 to 232
September . . . . . 233 to 258
October . . . . . 259 to 290
November . . . . . 291 to 312
December . . . . . 313 to 338

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Index to Advertisers

American College of Physicians 331
Avanti 329

Disability Determination **11**

Glaxo **6A, 6B, 6C, 6D**

Harreld Chevrolet-Oldsmobile 332
F. E. Hebert Hospital **10**

Eli Lilly and Company **7**

Medical Assurance Co. of Miss. **4**
MSMA Benefit Plan and Trust ..... **second cover**

Premier Printing 326

Roche Laboratories ..... **third, fourth covers**

Smith Kline and French 10B

Trustmark 328

The Upjohn Company **10A**
U. S. Air Force **9**

Harry Vickery 324

Jon Wimbish **6**
James Wooldridge Co. 321

Thomas Yates & Co. **12**



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EXCERPTS FROM A SYMPOSIUM
"THE TREATMENT OF SLEEP DISORDERS"[8]

"...highly effective for both sleep induction and sleep maintenance"

Sleep Laboratory Investigator
Pennsylvania

"...onset of action is rapid...provides sleep with no rebound effect to agitate the patient the following day"

Psychiatrist
California

"...appears to have the best safety record of any of the benzodiazepines"

Psychiatrist
California

After 15 years, the experts still concur about the continuing value of Dalmane (flurazepam HCl/ Roche). It provides sleep that satisfies patients... and the wide margin of safety that satisfies you.

The recommended dose in elderly or debilitated patients is 15 mg. Contraindicated in pregnancy.

DALMANE®

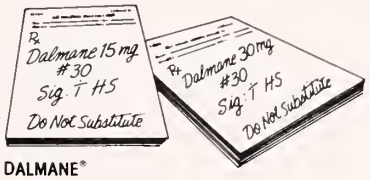
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sleep that satisfies

15-mg/30-mg
capsules



References: 1. Kales J, *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. 2. Kales A, *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. 3. Kales A, *et al: Clin Pharmacol Ther 19*:576-583, May 1976. 4. Kales A, *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. 5. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. 6. Dement WC, *et al: Behav Med*, pp 25-31, Oct 1978. 7. Kales A, Kales JD: *J Clin Psychopharmacol 3*:140-150, Apr 1983. 8. Tennant FS, *et al*: Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984. 9. Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977.



DALMANE®
brand of
flurazepam HCl/Roche Ⓥ

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits, in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms rarely reported, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults*: 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients*: 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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#1 FOR SLEEP

After more than 15 years of use, it's #1 for sleep that satisfies. Patients are satisfied because they fall asleep fast and stay asleep till morning.[1-8] And *you're* satisfied by the exceptionally wide margin of safety.[7-9] As always, caution patients about driving or drinking alcohol.

Please see adjacent page for references and summary of product information.

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NOT RENEWABLE AFTER 8 WEEKS

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